Department of Labor—Federal Security Agency Appropriations for 1954

HEARINGS

BEFORE THE

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

EIGHTY-THIRD CONGRESS

FIRST SESSION

UNIV. OF MICH.
MAR 1 1953
LIBRARY

SUBCOMMITTEE ON LABOR-FEDERAL SECURITY APPROPRIATIONS

FRED E. BUSBEY, Illinois, *Chairman*

BEN F. JENSEN, Iowa
HAMER H. BUDGE, Idaho
JOHN E. FOGARTY, Rhode Island
ANTONIO M. FERNANDEZ, New Mexico

ROBERT M. MOYER, *Executive Secretary to the Subcommittee*

FEDERAL SECURITY AGENCY

PART 2

Printed for the use of the Committee on Appropriations

Department of Labor—Federal Security Agency Appropriations for 1954

HEARINGS

BEFORE THE

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

EIGHTY-THIRD CONGRESS

FIRST SESSION

SUBCOMMITTEE ON LABOR-FEDERAL SECURITY APPROPRIATIONS

FRED E. BUSBEY, Illinois, *Chairman*

BEN F. JENSEN, Iowa
HAMER H. BUDGE, Idaho
JOHN E. FOGARTY, Rhode Island
ANTONIO M. FERNANDEZ, New Mexico

ROBERT M. MOYER, *Executive Secretary to the Subcommittee*

FEDERAL SECURITY AGENCY

PART 2

Printed for the use of the Committee on Appropriations

UNITED STATES
GOVERNMENT PRINTING OFFICE
30853 WASHINGTON : 1953

COMMITTEE ON APPROPRIATIONS

JOHN TABER, New York, *Chairman*

RICHARD B. WIGGLESWORTH, Massachusetts
BEN F. JENSEN, Iowa
H. CARL ANDERSEN, Minnesota
WALT HORAN, Washington
GORDON CANFIELD, New Jersey
IVOR D. FENTON, Pennsylvania
JOHN PHILLIPS, California
ERRETT P. SCRIVNER, Kansas
FREDERIC R. COUDERT, JR., New York
CLIFF CLEVENGER, Ohio
EARL WILSON, Indiana
NORRIS COTTON, New Hampshire
GLENN R. DAVIS, Wisconsin
BENJAMIN F. JAMES, Pennsylvania
GERALD R. FORD, JR., Michigan
FRED E. BUSBEY, Illinois
EDWARD T. MILLER, Maryland
CHARLES W. VURSELL, Illinois
T. MILLET HAND, New Jersey
HAROLD C. OSTERTAG, New York
OAKLEY HUNTER, California
FRANK T. BOW, Ohio
HAMER H. BUDGE, Idaho
CHARLES R. JONAS, North Carolina
OTTO KRUEGER, North Dakota
ROMAN L. HRUSKA, Nebraska
SAM COON, Oregon
MELVIN R. LAIRD, Wisconsin
ELFORD A. CEDERBERG, Michigan

CLARENCE CANNON, Missouri
GEORGE H. MAHON, Texas
HARRY R. SHEPPARD, California
ALBERT THOMAS, Texas
MICHAEL J. KIRWAN, Ohio
W. F. NORRELL, Arkansas
JAMIE L. WHITTEN, Mississippi
GEORGE W. ANDREWS, Alabama
JOHN J. ROONEY, New York
J. VAUGHAN GARY, Virginia
JOHN E. FOGARTY, Rhode Island
ROBERT L. F. SIKES, Florida
ANTONIO M. FERNANDEZ, New Mexico
PRINCE H. PRESTON, JR., Georgia
OTTO E. PASSMAN, Louisiana
LOUIS C. RABAUT, Michigan
SIDNEY R. YATES, Illinois
FRED MARSHALL, Minnesota
JOHN J. RILEY, South Carolina
ALFRED D. SIEMINSKI, New Jersey

GEORGE Y. HARVEY, *Clerk*
KENNETH SPRANKLE, *Assistant Clerk*

DEPARTMENT OF LABOR-FEDERAL SECURITY AGENCY APPROPRIATIONS FOR 1954

TUESDAY, MARCH 24, 1953.

PUBLIC HEALTH SERVICE

STATEMENT OF THE SURGEON GENERAL

WITNESSES

DR. LEONARD A. SCHEELE, SURGEON GENERAL
DR. W. PALMER DEARING, DEPUTY SURGEON GENERAL
DR. OTIS L. ANDERSON, CHIEF, BUREAU OF STATE SERVICES
DR. HALSEY HUNT, ACTING CHIEF, BUREAU OF MEDICAL SERVICES
DR. WM. H. SEBRELL, DIRECTOR, NATIONAL INSTITUTES OF HEALTH
ROY L. HARLOW, CHIEF FINANCE OFFICER
M. A. STEPHENS, BUDGET OFFICER, FEDERAL SECURITY AGENCY

Mr. BUSBEY. The committee will come to order.

We have before us for consideration the appropriation requests for the Public Health Service for the fiscal year 1954. Before we proceed with the detailed consideration of these requests we are happy to have with us Dr. Scheele, the Surgeon General of the Public Health Service, to tell us about some of the recent developments in this most important field and about the job that lies ahead.

Dr. Scheele, we will be pleased to hear any statement you wish to make.

GENERAL STATEMENT

Dr. SCHEELE. I am grateful for this privilege of appearing before you and the members of your committee. These annual hearings have always appealed to me because they give us an opportunity to talk across the table and, among other things, bring you and your committee up to date on our current activities, as well as our plans and programs for the coming year.

REPORT ON STATE OF HEALTH OF THE NATION

Before discussing operations and programs of the Public Health Service, I should like to give you a brief report on the state of health of the Nation.

The people of the United States today enjoy the longest life expectancy in the recorded history of man—an average of 68 years. Impressive as this figure is, it is even more impressive when we consider how swiftly it has risen. Life expectancy today is 3 years greater than it was in 1941. It is 8 years greater than in 1930. It has increased by 21 years since the turn of the century.

These achievements stem in great part from the extraordinary discoveries of medical research during the years of this century and from the applied knowledge, skill, and devotion of the private physicians, scientists, and health agencies of the country.

Yet even as we reflect on our achievements, we realize that many tasks still confront us. We cannot afford to be complacent. We would be foolish if we failed to realize that many serious problems have been created or intensified by the very progress we have made.

As more people survive the hazards of infancy and childhood, more of us enter the age groups in which cancer and the diseases of the heart, kidney, and blood vessels—the cardiovascular-renal diseases—take their toll.

In 1900, they were responsible for less than one-fourth of all deaths, but it is a hard fact that these diseases accounted for more than two-thirds of all deaths in the United States in 1951. Staggering as is the toll of death from chronic disease its full significance can only be appreciated when we remember that these are the diseases which often disable their victims for years and cause great economic waste.

We also must face up to other challenges. Despite substantial progress in communicable-disease control, there remains a long list of infections for which practical measures of prevention—and, in some instances effective treatment—are not known. The list is still too long. Some are frequent diseases like the common cold—others rare—but all of them cost time, money, comfort and—in some instances—life.

Other communicable diseases for which we do have controls—such diseases as typhoid fever, malaria, diphtheria, and other ancient scourges—have not totally disappeared from the earth. Rather, they are kept under control by the ceaseless vigil of the medical profession and health agencies. We continue to seek their final and complete eradication.

And we also need to understand more clearly than we do now the factors that give rise to physical and mental disorders.

These are some of the tasks which confront the physicians and the voluntary and the official health agencies of the Nation. They are the tasks which, more and more, are becoming the very heart of our programs as defined and supported by Congress.

I should like to review for you, especially for the new members of the committee, how the work of the Service fits into the general scheme of the Nation's health services.

Our programs fall generally into three broad sectors: (1) a working partnership with the States and local communities; (2) direct medical services for certain categories of Federal beneficiaries; and (3) research.

LOCAL, STATE, AND FEDERAL RELATIONSHIPS

The partnership of local, State, and Federal Governments in the prevention of disease and the promotion of the public health is based on a long, well-established, and, I believe, satisfactory pattern of working together to accomplish a common goal.

Health problems in States and communities are basically the problems of the States and communities. They plan and carry out the actual provisions of public-health services to their people. Only those functions which are beyond the capacity of individual States

fall to the Public Health Service. For example, we foster and conduct research and investigations to find new and improved public-health techniques, to collect national statistics, to undertake the solution of interstate and international health problems, and to provide technical and financial assistance to States in their task of providing public-health services for the people.

There is one important point I would like to make concerning our partnership with the States and communities. Our activities do not supplant or duplicate what the States and localities can and should do for themselves. They do not result in Federal supervision of State and local public-health operations but rather are carried out so that the States retain their independence of decision and action.

TECHNICAL SERVICES

One of the ways in which we help the States in meeting their health problems is through the consultant services and assistance which our experts provide, as for example: Our epidemiologists, who are trained to track down quickly the source of epidemics; our sanitary engineers who are specialists in such problems as the control of wastes that pollute our waters; our medical and other specialists in the control of such diseases as syphilis, tuberculosis, cancer, and heart disease.

Together these men and women constitute a pool of specialist talent which few States could afford separately, but which are available to all of the States and communities to help them do a better job and to reduce to a minimum the time lag between the discovery of new knowledge and its application by State and local public-health personnel.

PUBLIC HEALTH GRANTS

Our administration of financial grants-in-aid is another illustration of cooperative relations with the States. These grants—for both general health and specialized disease-control programs as well as for the planning and construction of hospitals—are designed to help the States in maintaining a reasonable level of public-health activity and to help stimulate the development of new programs for the solution of public-health problems.

Since the inception of the Federal-grant program, the State health departments have continued to grow and to expand the services they are giving to their people. Measured in terms of what our health problems were in the past, the gains made have been truly remarkable. But when we consider the complexities of today's problems, we realize that the States and communities still have a long way to go.

HOSPITAL CONSTRUCTION

I am sure that you are well acquainted with the hospital-construction program under the Hill-Burton Act. The major purpose of that act is to assist the States to provide "adequate hospital, clinic, and similar services to all their people," with most of the cost being borne by the States and local communities. For the fiscal years 1948 through 1953 Federal appropriations and contract authorizations have amounted to $542½ million, and State-local expenditures to twice that amount. The original act authorized annual appropriations to $75 million. This was amended in October 1949, to authorize

annual appropriations of $150 million but the larger amount was made available in 1 year only—1950.

The first hospital project was completed and opened in October 1948; by August 1952, 1,000 facilities had been built and were in operation. As of this date the total number of approved projects is in the neighborhood of 2,000. These projects, when completed, will add close to 100,000 hospital beds and almost 400 public-health centers to the Nation's health resources. Most of these hospitals are in needy rural areas. We are proud of that record, of course, but the studies of the State agencies which were established pursuant to the act show that the present deficiency in acceptable hospital beds is more than 800,000. We must keep in mind that as our population increases—and as it ages—the demand for hospital beds will also increase.

DIRECT MEDICAL CARE

Medical care for merchant seamen cradled the Public Health Service. Indeed, the Service came into being on July 16, 1798, when our second President, John Adams, signed an act which established theMarine Hospital Service to provide medical care for sick and disabled seamen.

The oldest of our responsibilities is now carried on in the 18 hospitals and a considerably larger number of outpatient facilities which are operated by the Service. In addition to merchant seamen, our beneficiaries include members of the Coast Guard, Federal employees injured in line of duty, and a number of smaller groups.

Two of our institutions are psychiatric hospitals primarily for the treatment of drug addiction—one at Lexington, Ky., and the other at Fort Worth, Tex. At Carville, La., we also have the only hospital in the country devoted entirely to the treatment of persons afflicted with Hansen's disease, leprosy.

QUARANTINE

Our second oldest function—quarantine, both interstate and foreign—is, with the exception of biologics control, the only law-enforcing activity of the Service. Interstate quarantine regulations, which were initially established to control the spread of epidemics, now cover such areas as sanitation on interstate carriers and in shellfish beds. Our foreign quarantine activities, of course, are designed to prevent the introduction of epidemics from foreign countries. These are continuing services which must be maintained.

RESEARCH IN MEDICAL AND RELATED SCIENCES

Medical research is the keystone of any effort to improve human health. It is medical trail-blazing. Most of the measures which are so successful today in the control of diseases were charted first in the minds of research workers. And it is to these research workers that we must look for the solution of the new problems which now confront us.

The research funds provided in this budget support the work of our own investigators and the work of scientists in medical schools, universities, hospitals, and other non-Federal institutions.

I should like to point out that two-thirds of our research funds are used to support investigations outside the Government.

FINANCIAL ASSISTANCE TO NONFEDERAL INSTITUTIONS AND DIVIDENDS

The assistance to non-Federal institutions and individuals is given after thorough review by and on the recommendation of advisory councils and study sections composed of non-Federal experts. The councils were prescribed by Congress. These consultants are drawn from medical schools, universities, and public affairs in all parts of the Nation and meet with us several times each year to help insure that only the best medical-research projects are selected for financial support. Under the law no research grant may be made by the Public Health Service unless it has the approval of the responsible, appropriate advisory group. Once the grant is made, the scientists are totally free from Federal supervision.

We also work closely with national voluntary health organizations such as the American Cancer Society, the American Heart Association, and the Arthritis and Rheumatism Foundation, and many others, so that our research and training programs are integrated closely with those which they sponsor.

I should like to mention a few achievements in just one broad general area to illustrate what is being accomplished under this program of assistance to non-Federal scientists.

During the past year, scientists receiving grants and fellowships from our National Heart Institute have developed a plastic disk which has been used successfully in animals to repair holes in the heart partitions. Another development has been the technique for widening (through cutting) the constricted aortic valve which occurs in the condition known as aortic stenosis. In addition, a plastic aortic valve has been used with success on human beings.

The year marked another event of historic significance in the field of heart disease. A mechanical heart has been used for the first time to help a human being through a delicate operation. Several types of artificial heart-lung machines were also brought to advanced stages of development. With their continued improvement, it is almost certain that a dependable instrument will result in the not too distant future. The general availability of such an instrument would make possible much heart and other surgery which cannot now be undertaken.

RESEARCH CONTRIBUTIONS BY PUBLIC HEALTH SERVICE SCIENTISTS

Other research, by our own Public Health Service scientists, is paying off.

At the annual meeting of the American Society of Tropical Medicine just a few weeks ago, for example, Public Health Service announced successful results in the treatment of malaria with a new drug called daraprim. This drug promises to be even more effective in the suppression and cure of malaria than two other drugs, chloroquin and primaquin, that our scientists also helped test. In working with all three of these drugs, we collaborated closely with the armed services, the Federal Bureau of Prisons, medical school and university scientists, and with the laboratories of several pharmaceutical houses. If the very promising results obtained so far with daraprim hold up in large-scale field tests, it may prove to be of inestimable value to our people who work or serve in our armed services in malarious areas of the world including Korea.

Our scientists, working with other scientific groups over the past few years have developed and are now in process of perfecting a device for recording accurately the movements of the heart and great vessels. This device, known as the electrokymograph, provides additional help in diagnosing the condition of patients suffering damaged heart muscles, valvular lesions, and diseased heart sacs. It also is most useful in studying variations of the activity of the heart in the presence of congestive heart failure and provides another means of measuring cardiac output which is important in determining the work capacity of heart patients.

Our scientists within the past year have also found that in animals the fatal hemorrhage that follows exposure to heavy doses of radiation can be prevented by transfusions of small blood components known as platelets. More research needs to be done, but enough evidence already is at hand to suggest that these preventive procedures may prove highly significant to persons exposed to lethal radiation from X-ray machines or atomic energy.

A few months ago a group of our research workers completed studies which are widely accepted as being a long step forward in understanding the factors involved in the development of atherosclerosis—hardening of the arteries. It is hoped that their discovery may provide a key leading to the development of a routine blood test that will detect hardening of the arteries in its early stages. If this promise is fulfilled it could mean an early diagnosis of the disease and an effective treatment procedure.

A membrane filter, a wartime invention, has been developed to a high stage of practical use by which water-plant operators can determine rapidly and economically the bacterial content of the water. Doubtless you read of its use in connection with water-supply problems at the local Pullman City during the recent inauguration.

Research carried on in Colorado has determined the extent of health hazards from radiation in uranium mines and mills and methods of controlling them are now being followed by industry.

Studies are being made of rapid physical and biological methods of identifying disease agents recovered from the atmosphere. This information will be of practical value both in peacetime and in war.

I have mentioned only a few of many accomplishments. Undoubtedly as you progress with the hearing and the study of activities of our institutes and divisions, more of the heart-warming results of medical research in our own and other laboratories will be discussed.

CLINICAL CENTER

In the past when the Public Health Service was concerned mainly with infectious diseases, clinical study could be done in conjunction with our efforts in the field to control epidemics. With the emergence of the chronic diseases as major problems, it became essential that clinical facilities be added. I am pleased to report that the Clinical Center in Bethesda, which has been under construction for several years, is scheduled to receive its first patients in the near future.

The center will ultimately provide up to 500 beds for study of these diseases which most greatly affect our people. Patients will be sent to us by physicians in medical schools, hospitals, and in private practice in various parts of the country.

In accordance with a policy already well established, the Clinical Center will provide facilities not only for our own scientists but also for distinguished medical scientists from universities, hospitals, and medical schools who will work in collaboration with us on problems of common interest.

PROGRESS OF RESEARCH

Never before in history has there been such a strong and concerted attack on the unsolved problems of human health.

The progress being made in our own laboratories and in our hospitals, universities, and medical schools generally permits an optimistic view of the future. If the volume and intensity of this research can be maintained over a period of years, and if the few areas of weakness can be bolstered, it is certain that within the lifetime of many of us the suffering, the human wastage, and the economic cost of cancer, heart disease, arthritis, and mental illness, and the other major problems today can be greatly reduced.

Similarly, as our cities and industries grow, our environmental health problems increase in magnitude and complexity. New processes add untested chemicals and radioactive substances to air, water, and food. We look to our new Environmental Health Center, in Cincinnati, to help provide practical answers to the questions of evaluation and control.

I am sure you agree that all health problems have not as yet been solved.

Cancer, a disease of the middle and later years, is at the highest rate that it has ever reached.

Heart disease has increased markedly within the lifetime of all of us. In the short period since 1940 the death rate from these diseases has increased steadily until it is now over 355 per hundred thousand.

ADVANCEMENT IN DEVELOPING PREVENTIVE FOR POLIOMYELITIS

You will have read, I am sure, of the recent announcement by the National Foundation for Infantile Paralysis of the dramatic advances that have been made during the past few months in developing a preventive for poliomyelitis.

These discoveries were the result of literally years of effort, time, and expenditure—by scientists in and out of Government and by countless research assistants.

I might say that it cost the Polio Foundation $1 million to put on the field trial for 2 years on gamma globulin. The gamma globulin itself was donated by the Red Cross. That is material that will be provided free by the Red Cross and the Polio Foundation to the States in this present polio season which is just beginning, to prevent some of the paralytic polio that otherwise occurs.

ROLE OF RESEARCH

The answer to the riddle of cancer and of various forms of heart disease will come about in similar fashion—the announcement of a clue, the development of new leads from that clue, the gradual perfecting of cures and controls.

This is the long promise of research.

There are many other areas which demand the Nation's attention.

Rheumatism, for example, afflicts some seven and a half million annually. Eight and one-half million of our fellow citizens suffer from some sort of mental illness. Our national dental expenditures have been estimated to run as high as $1 billion annually.

Research to reduce this toll is the joint effort of private physicians, scientists in our universities and medical schools, laboratory men of private industry, and the Public Health Service, and other Government laboratories. The Congress wisely has been aiding this program by appropriations for research grants and direct research activities.

PROBLEM OF EPIDEMICS OF COMMUNICABLE DISEASES

In spite of all our progress, I repeat, the job has by no means been completed in the communicable diseases. There are over 2 million cases of communicable diseases every year in the United States. Our State health departments, our local health facilities, and our Federal quarantine- and disease-detection activities must remain alert to the threat of epidemics and to the job of coping with community sanitary measures which are increasing in complexity and importance with the growth of American community life.

The threat inherent in our polluted streams—which recognize neither State nor county lines—is a continuing national challenge.

The Public Health Service has been assisting not only in maintaining but also in strengthening our defenses against diseases. I should like to cite one illustration—the development during the past several years of our epidemic intelligence force, a group of physicians and other personnel trained to cope with epidemics.

Last year we answered more than 200 calls for aid from local and State health officials. Among them were a serious outbreak of encephalitis in California, of typhoid in Colorado, of infectious hepatitis in Tennessee, and of malaria among Camp Fire Girls in the foothills of California's Sierra Nevada Mountains.

Effective in peacetime, this group, we believe, would be a strong arm of civil defense against any threat of biological warfare.

There are other problems, many of them peculiar to our troubled times. The rapid expansion of industrial production, the dislocation of segments of our population occasioned by our defense effort, the 500 million man-days lost to industry each year through sickness and absenteeism, the stubborn problem of obtaining sufficient medical manpower to man our State and local health departments and the Nation's growing research effort—all these face us in the months and years ahead. We must seek solutions for them. None will be solved over night. There are few which will not yield, in time, to concerted and sustained attack.

It is easy to overlook the value of public-health measures. Sanitation, licensing of biological products, foreign quarantine, venereal-disease control, early detection measures for tuberculosis, cancer, and other diseases; and the whole array of protective measures against disease outbreaks, are not spectacular but they are vital. They appear routine day by day and month by month, but they are spectacular in the perspective of the years.

CAMPAIGN FOR MEDICAL RESEARCH

While the control measures protect against the known, medical research on the unknowns must go forward if standards of health are to rise in the decades ahead as they have in the past. Since World War II this country has launched the most intensive medical research campaign in the history of this or any other country. This campaign is now under way with solid momentum. The predicted flow of findings after a 5-year period of expanded support is now appearing.

The Nation needs a fully productive work force. Industrial health hazards are multiplying. Ths possibilities of the importation of diseases are still with us. Dislocations of large population groups leave us vulnerable to outbreaks of disease, either natural or induced.

These are the lines of reasoning that have led me to the conviction that these public-health expenditures continue to be vitally important, especially at this time. Standing alone, my views might be discounted as those of a special pleader, but it seems to me that the Hoover Commission must have been influenced by similar ideas when it incorporated the following statement in one of its reports:

> The health of the nation demands the maximum employment of present scientific knowledge to control disease, and of research to find new methods for the prevention of disease. * * * The Nation's fate can best be protected by using every means to *prevent* disease, rather than by providing unlimited hospitalization o treat it.

I have emphasized the word "prevent" because the prevention of disease is the shortest and most expressive definition I know for the practice of public health.

I like to think of our budget as representing our part in the total health activities of the country, in which we are making contributions along several lines, but with most of our energies and resources concentrated on those things which contribute to the betterment of the practice of preventive medicine.

In closing I should like to repeat, Mr. Chairman, that I appreciate this opportunity to appear before your committee. As the various appropriations are heard, we will present as witnesses, subject to your call, those who are in direct charge of the work and know the details of each of our many varied specialized programs.

I want to assure you that we are reviewing our programs and are taking steps to improve our operations and management and to effect economies.

It will be our aim to get the most out of every health dollar you find it possible to appropriate for our work.

Now, Mr. Chairman, I want to indicate that I have with me this morning Dr. W. P. Dearing, the Deputy Surgeon General; Mr. Roy Harlow, the chief finance officer, a man well known to you, and our Bureau and Institute chiefs, Dr. Henry Sebrell, who is the Director of the National Institutes of Health, Dr. Otis Anderson, Chief of the Bureau of State Services, and Dr. Halsey Hunt, Acting Chief of the Bureau of Medical Services, and then, of course, Mr. Stephens, the Agency budget officer, who is well known to you.

Mr. BUSBEY. Thank you, Dr. Scheele.

I wonder if you could give the committee a little more detail in regard to the advisory councils and study sections that you refer to on page 6 of your prepared statement. In this connection it might be well to trace a cancer-research grant, for example, from the original application to final payment of the grant so that we can see exactly how the grant procedure functions.

Dr. SCHEELE. I shall be glad to do that.

The projects we support in cancer, and the other medical research fields, are not projects originated in the Public Health Service. These are projects which originate in the minds of research people outside of Government.

This would be a typical situation: An investigator in a hospital, or a university, or a medical school, or an independent laboratory, develops an idea that he would like to do research on, but he does not have the resources to support him. He takes an application form which we provide and fills in the necessary information, which is a description of his project. He describes the funds which he would like to receive through the Public Health Service, breaks that down by objects so that we can see what he wants in the way of personnel and supplies and what his other expenses will be. He is asked also to tell who else he has asked for money, or what other source of support he has, because sometimes on a given project there is considerable support from within the university or other sources, and our support would be only partial.

Then this application form is sent up through the official head of his school. I might say in some cases it would go through an additional person. If he is not the head of a department, his department head would endorse it and it would then go to the head of the medical school if it was in a medical school, or the head of a laboratory, who in turn would transmit it to us with his endorsement. We would know this was not an individual wanting to do something which did not have the full endorsement of the organization within which he worked.

This would be received in the Division of Research Grants and Fellowship in the National Institutes of Health, where it would be processed into duplicate copies, and those copies would then be transmitted to the appropriate members of the National Advisory Council concerned. In the case of a cancer project, copies would be sent to each of the Cancer Council members. In this case, as in all our councils, there are 6 professional members and 6 nonprofessional members. They would have it to study in the interval before coming to one of the regular periodic meetings that we have. At the same time, a determination would be made regarding the study section, or study sections, that would have the technical competence to review the particular project because of its nature, and copies would be sent to the study-section members in advance of a meeting. Then the project would be discussed by them at a formal meeting prior to going to a council meeting. They would discuss the pros and the cons of the project, the caliber of the investigator, and would come forth with a voted opinion on whether the project was good, should be supported in whole, should be rejected, should be modified, and

then that recommendation is sent to the Surgeon General of the Public Health Service.

That same recommendation is passed then to the council members who under the law are the final recommending authority to the Surgeon General. Also, under the law, the Surgeon General may not approve a project that the council does not recommend. If the council finds that a project is not worthy of support, the Surgeon General may not support it. The Surgeon General may reverse the panel. That is a practice seldom engaged in, however, because we do not have the ability to judge these as well, ordinarily, as do these technical people who have screened them before they come to the Surgeon General. So, the study section's recommendation is then before the council. The council in meeting reconsiders the project. It may determine it will agree with the study section, support the program. It may be that they will disagree, and we will then in their behalf pass their comments back to the study section for additional consideration. if they feel that is necessary.

Tracing this on through, assuming that this project that we are talking about was strongly recommended by the study section, and was strongly recommended by the council, the Surgeon General would accept their recommendation, and the appropriate officials in the National Institutes of Health would write to the man who had asked for the funds telling him that his project had been approved and that at the appropriate time a check would be sent to him to cover the cost of his project.

NATIONAL ADVISORY COUNCILS AND STUDY SECTIONS

I would like to add an additional thing for the new members. I did describe the councils. These are created in law. We have seven of them. We have one on cancer, one on heart, one in arthritis and metabolic diseases, one in neurology and blindness, one in dental health, one in mental health, and one in the overall area called the National Advisory Health Council.

Mr. BUSBEY. Dr. Scheele, I am sure it would be of value if the personnel of these various councils were to be included in the record at this point.

Dr. SCHEELE. With your permission, we will supply those.

(The information requested is as follows:)

NATIONAL ADVISORY HEALTH COUNCIL

Authority.—Established by law in July 1902 (Public Law 236, 57th Cong.) as the Advisory Board for the Hygienic Laboratory. Renamed the National Advisory Health Council in April 1930 by Public Law 106, 71st Congress. Re-established pursuant to section 217 of the Public Health Service Act (Public Law 410, 78th Cong.) as amended by Public Law 692, 81st Congress.

Structure.—Consists of the Surgeon General as Chairman, the Chief Medical Officer of the Veterans' Administration or his representative, and a medical officer designated by the Secretary of Defense who serve as ex officio members; and 12 members appointed by the Surgeon General with approval of the Administrator who are leaders in the fields of fundamental sciences, medical sciences, or public affairs. Six of these members are leading medical or scientific authorities outstanding in the sciences relating to health. Members are appointed for overlapping terms of 4 years and no member is eligible for reappointment within 1 year after the end of his preceding term.

Function.—Reviews applications for grants-in-aid relating to research projects of either general or microbiological nature, and recommends to the Surgeon General

the approval of those projects which merit support. Consults with and advises the Surgeon General on matters relating to health activities and functions of the Service. Recommends regulations providing for apprehension, examination, and detention of persons known to be spreading communicable diseases from State to State.

Meetings.—Three meetings are held annually—usually in February, June, and October.

Member	Organization	Address
Scheele, Dr. Leonard A. (Chairman)[1]	Public Health Service	Washington, D. C.
Boone, Vice Adm. Joel T.[1]	Veterans' Administration	Do.
Bryce, William H. (56)	Dixie Wax Paper Co	Post Office Box 2607, Memphis, Tenn.
Casberg, Dr. Melvin A.[1]	Department of Defense	Washington, D. C.
Eliassen, Dr. Rolf (56)	Massachusetts Institute of Technology.	Cambridge, Mass.
Gustavson, Dr. R. G. (54)	University of Nebraska	Lincoln, Nebr.
Halverson, Dr. Wilton L. (53)	State department of health	668 Phelan Bldg., San Francisco, Calif.
Heyman, David M. (55)		61 Broadway, New York, N. Y.
Hollander, Louis (53)	New York State Council, CIO	31 West 15th St., New York, N. Y.
Larabee, Byron H. (56)	Firestone Plantations Co	Akron, Ohio.
Loeb, Dr. Robert F. (54)	Columbia University College of Physicians and Surgeons.	620 West 168th St., New York, N. Y.
Means, Dr. J. H. (55)	Massachusetts Institute of Technology.	Cambridge, Mass.
Reed, Dr. Lowell J. (54)	Johns Hopkins University	601 North Broadway, Baltimore, Md.
Smith, Dr. Charles E. (55)	University of California School of Public Health.	Berkeley, Calif.
Tobias, Dr. Channing H. (53)	Phelps-Stokes Fund	101 Park Ave., New York, N. Y.

[1] Ex officio.

National Advisory Cancer Council

Authority.—Established by law in August 1937 pursuant to Public Law 244, 75th Congress, superseded by section 217 of the Public Health Service Act (Public Law 410, 78th Cong.), as amended by Public Law 692, 81st Congress.

Structure.—Consists of the Surgeon General as Chairman, the Chief Medical Officer of the Veterans' Administration or his representative, and a medical officer designated by the Secretary of Defense who serve as ex officio members; and 12 members appointed by the Surgeon General with approval of the Administrator who are leaders in the fields of fundamental sciences, medical sciences, or public affairs. Six of these members are leading medical or scientific authorities outstanding in the study, diagnosis, or treatment of cancer. Members are appointed for overlapping terms of 4 years and no member is eligible for reappointment within 1 year after the end of his preceding term.

Function.—Reviews applications for grants-in-aid relating to research, teaching, or control projects in the field of cancer, and recommends to the Surgeon General approval of those projects which merit support. Makes recommendations to the Surgeon General on matters relating to programs and activities in the area of cancer and with respect to acceptance of conditional gifts pursuant to section 501 of the Public Health Service Act.

Meetings.—Three meetings are held annually—usually in February, June, and October.

Member	Organization	Address
Scheele, Dr. Leonard A. (Chairman).[1]	Public Health Service	Washington, D. C.
Adams, James S. (53)	Lazard Freres Co.	44 Wall St., New York, N. Y.
Aub, Dr. Joseph C. (55)	Massachusetts General Hospital	Boston, Mass.
Boone, Vice Adm. Joel T.[1]	Veterans' Administration	Washington, D. C.
Casberg, Dr. Melvin A.[1]	Department of Defense	Do.
Chamberlain, Dr. W. Edward (55).	Temple University Hospital	3401 North Broad St., Philadelphia, Pa.
Gardner, Dr. W. U. (54)	Yale University School of Medicine.	333 Cedar St., New Haven, Conn.
Goldblatt, Maurice (54)		333 South State St., Chicago, Ill.
Miller, Mrs. Lois Mattox (53)		1088 Park Ave., New York, N. Y.
Morton, Dr. John J. (54)	Rochester University Medical School.	Rochester, N. Y.
Payne, Hugh G. (55)	Oklahoma Medical Research Foundation.	825 Northeast 13th St., Oklahoma City, Okla.
Stanley, Dr. W. M. (56)	University of California	Berkeley, Calif.
Steiner, Dr. Paul E. (53)	University of Chicago	Chicago, Ill.
Thompson, Mrs. Marguerite P. (56).		2325 13th St., Boulder, Colo.
Woolfolk, Ellis T. (56)		Tunica, Miss.

[1] Ex officio.

National Advisory Mental Health Council

Authority.—Established by law in July 1946 pursuant to section 217 of the Public Health Service Act (Public Law 410, 78th Cong.), as amended by Public Law 487, 79th Congress, and Public Law 692, 81st Congress.

Structure.—Consists of the Surgeon General as Chairman, the Chief Medical Officer of the Veterans' Administration or his representative, and a medical officer designated by the Secretary of Defense who serve as ex officio members; and 12 members appointed by the Surgeon General with approval of the Administrator who are leaders in the fields of fundamental sciences, medical sciences, or public affairs. Six of these members are leading medical or scientific authorities outstanding in the study, diagnosis, or treatment of psychiatric disorders. Members are appointed for overlapping terms of 4 years, and no member is eligible for reappointment within 1 year after the end of his preceding term.

Function.—Reviews applications for grants-in-aid relating to research, training, and instruction in the field of psychiatric disorders and recommends to the Surgeon General approval of those projects which merit support. Collects information as to studies being carried on in the United States and abroad relating to psychiatric disorders and makes such information available to interested individuals and organizations. Consults with the Surgeon General on acceptance of conditional gifts pursuant to section 501 of the Public Health Service Act.

Meetings.—Three meetings are held annually—usually in February, June, and October.

Member	Organization	Address
Scheele, Dr. Leonard A. (chairman).[1]	Public Health Service	Washington, D. C.
Blackwell, Dr. Gordon W. (55)	University of North Carolina	Chapel Hill, N. C.
Boone, Vice Admiral Joel T.[1]	Veterans' Administration	Washington, D. C.
Casberg, Dr. Melvin A.[1]	Department of Defense	Do.
Darley, Dr. Ward (55)	Colorado University Medical Center.	Denver, Colo.
Gerty, Dr. Francis J. (56)	University of Illinois College of Medicine.	8 South Michigan Ave., Chicago, Ill.
Hilgard, Dr. Ernest R. (56)	Stanford University	Stanford, Calif.
Magoun, Dr. Horace W. (56)	University of California Medical School.	Los Angeles, Calif.
Mahoney, Mrs. Florence (54)		3616 Prospect Ave. NW., Washington, D. C.
Malamud, Dr. William (54)	Boston University School of Medicine.	80 East Concord St., Boston, Mass.
May, Ben (54)		Mobile, Ala.
Schlaifer, Charles (53)		4 West 58th St., New York, N. Y.
Scoville, Miss Mildred C. (53)	The Commonwealth Fund	1 East 75th St., New York, N. Y.
Wortis, Dr. S. Bernard (53)		410 East 57th St., New York, N. Y.
(Vacancy)		

[1] Ex officio.

National Advisory Heart Council

Authority.—Established by law in June 1948 pursuant to section 217 of the Public Health Service Act (Public Law 410, 78th Cong.), as amended by Public Law 655, 80th Congress and Public Law 692, 81st Congress.

Structure.—Consists of the Surgeon General as Chairman, the Chief Medical Officer of the Veterans' Administration or his representative, and a medical officer designated by the Secretary of Defense who serve as ex officio members; and 12 members appointed by the Surgeon General with approval of the Administrator who are leaders in the fields of fundamental sciences, medical sciences, or public affairs. Six of these members are leading medical or scientific authorities outstanding in the study, diagnosis, or treatment of heart diseases. The remaining six lay members are outstanding in their interest and activities in medical and public-health problems of a community nature. Members are appointed for overlapping terms of 4 years and no member is eligible for reappointment within 1 year after the end of his preceding term.

Function.—Reviews applications for grants-in-aid relating to research and training projects in the field of heart diseases and recommends to the Surgeon General the approval of those projects which merit support. Collects information as to studies being carried on in the United States and abroad relating to heart diseases and makes such information available to interested individuals and organizations. Consults with the Surgeon General on acceptance of conditional gifts pursuant to section 501 of the Public Health Service Act.

Meetings.—Three meetings are held annually—usually in February, June, and October.

Member	Organization	Address
Scheele, Dr. Leonard A. (Chairman).[1]	Public Health Service	Washington, D. C.
Boone, Vice Adm. Joel T.[1]	Veterans' Administration	Washington, D. C.
Brown, Raymond R. (56)		812 Southwest Washington St., Portland, Oreg.
Casberg, Dr. Melvin A.[1]	Department of Defense	Washington, D. C.
Jones, Dr. T. Duckett (54)	Helen Hay Whitney Foundation	525 East 68th St., New York, N. Y.
Lasker, Mrs. Mary W. (54)		Chrysler Bldg., New York, N. Y.
Marvin, Dr. H. M. (53)		303 Whitney Ave., New Haven, Conn.
Neely, Frank (55)	Rich's Incorporated	Broad and Alabama Sts., Atlanta, Ga.
Oreck, Erwin (53)		31 West Superior St., Duluth, Minn.
Page, Dr. Irvine H. (53)	Cleveland Clinic Foundation	Cleveland, Ohio.
Prinzmetal, Dr. Myron (56)	Cedars of Lebanon Hospital	4751 Fountain Ave., Los Angeles, Calif.
Turner, Dr. Edward L. (55)	Washington Univ. School of Medicine.	Seattle, Wash.
White, Dr. Paul D. (54)		264 Beacon St., Boston, Mass.
(Vacancy)		

[1] Ex officio.

National Advisory Dental Research Council

Authority.—Established by law in June 1948 pursuant to section 217 of the Public Health Service Act (Public Law 410, 78th Cong.), as amended by Public Law 755, 80th Congress and Public Law 692, 81st Congress.

Structure.—Consists of the Surgeon General as Chairman, the chief medical officer of the Veterans' Administration or his representative, and a medical officer designated by the Secretary of Defense who serve as ex officio members; and 12 members appointed by the Surgeon General with approval of the Administrator who are leaders in the fields of fundamental sciences, medical sciences, or public affairs. Six of these members are leading medical or scientific authorities outstanding in the study, diagnosis, or treatment of dental diseases or conditions and at least 4 of the 6 are dentists. Members are appointed for overlapping terms of 4 years and no member is eligible for reappointment within 1 year after the end of his preceding term.

Function.—Reviews applications for grants-in-aid relating to research, training, instruction, and traineeships in the field of dental diseases and recommends to the Surgeon General approval of those projects which merit support. Collects information as to studies being carried on in the United States and abroad relating to dental diseases and makes such information available to interested individuals and organizations. Consults with the Surgeon General on acceptance of conditional gifts pursuant to section 501 of the Public Health Service Act.

Meetings.—Three meetings are held annually—usually in February, June, and October.

Member	Organization	Address
Scheele, Dr. Leonard A. (Chairman).[1]	Public Health Service	Washington, D. C.
Armstrong, Dr. Wallace D. (56)	University of Minnesota Medical School.	Minneapolis, Minn.
Black, Dr. Alvin Percy (55)	University of Florida	Gainesville, Fla.
Boone, Vice Admiral Joel T.[1]	Veterans' Administration	Washington, D. C.
Brown, Mrs. Ethel (55)		1134 North Orange Dr., Los Angeles, Calif.
Casberg, Dr. Melvin A.[1]	Department of Defense	Washington, D. C.
Center, Mrs. Mayola S. (54)	State Department of Public Health.	Atlanta, Ga.
Davis, Watson (53)	Science Service	1422 Rhode Island Ave. NW. Washington, D. C.
Elvehjem, Dr. C. A. (54)	University of Wisconsin Graduate School.	Bascom Hall, Madison, Wis.
Harrington, Mark H. (53)	Shuteran, Robinson & Harrington	The Equitable Bldg., Denver, Colo.
Hill, Dr. Thomas J. (56)	Western Reserve University	2085 Adelbert Rd., Cleveland, Ohio.
Lowery, Dr. P. C. (53)		Lowery Bldg., Burns-Cratiot Ave., Detroit, Mich.
Nicholson, Arnold (56)	Curtis Publishing Co	Independence Sq., Philadelphia, Pa.
Reichmann, Dr. Francis J. (55)		514 Medical Arts Bldg., Oklahoma City, Okla.
Sebelius, Dr. Carl L. (54)	State Department of Public Health.	Nashville, Tenn.

[1] Ex officio.

National Advisory Arthritis and Metabolic Diseases Council

Authority.—Established by law in August 1950 pursuant to section 431 of the Public Health Service Act (Public Law 410, 78th Cong.), as amended by Public Law 692, 81st Congress.

Structure.—Consists of the Surgeon General as Chairman, the chief medical officer of the Veterans' Administration or his representative, and a medical officer designated by the Secretary of Defense who serve as ex officio members; and 12 members appointed by the Surgeon General with approval of the Administrator who are leaders in the fields of fundamental sciences, medical sciences, education, or public affairs. Six of these members are leading medical or scientific authorities outstanding in the study, diagnosis, or treatment of arthritis and metabolic diseases. Members are appointed for overlapping terms of 4 years, and no member is eligible for reappointment within 1 year after the end of his preceding term.

Function.—Reviews applications for grants-in-aid relating to research projects in arthritis, rheumatism, and metabolic diseases, and recommends to the Surgeon General the approval of those projects which merit support. Consults with and advises the Surgeon General on matters relating to programs and activities in the area of arthritis and metabolic diseases.

Meetings.—Three are held annually—usually in February, June, and October.

Member	Organization	Address
Scheele, Dr. Leonard A. (chairman).[1]	Public Health Service	Washington, D. C.
Barach, Dr. Joseph (55)	University of Pittsburgh School of Medicine.	3601 5th Ave., Pittsburgh, Pa.
Bauer, Dr. Walter (56)	Massachusetts General Hospital	Boston, Mass.
Boone, Vice Admiral Joel T.[1]	Veterans' Administration	Washington, D. C.
Casberg, Dr. Melvin A.[1]	Department of Defense	Do.
Cutler, Dr. Lawrence (55)		33 Grove St., Bangor, Maine.
Freyberg, Dr. Richard H. (53)	Cornell University Medical College.	321 East 42d St., New York, N. Y.
Harwick, Harry J. (56)		912 8th St. SW., Rochester, Minn.
Heller, Mrs. Elinor R. (53)		219 Atherton Ave., Atherton, Calif.
Hinckley, Robert H. (55)	American Broadcasting Company, Inc.	30 Rockefeller Plaza, New York, N. Y.
Holbrook, Dr. W. Paul (53)	Southwest Clinic & Research Institute.	2430 East 6th St., Tucson, Ariz.
Hutchison, Dr. Ralph C. (56)	Lafayette College	515 College Ave., Easton, Pa.
Odlum, Floyd B. (54)	Atlas Corp	33 Pine St., New York, N. Y.
Watson, Dr. Cecil J. (54)	University of Minnesota Medical School.	Minneapolis, Minn.
Wintrobe, Dr. Maxwell M. (54)	Salt Lake General Hospital	175 East 21st St. S., Salt Lake City, Utah.

[1] Ex officio.

National Advisory Neurological Diseases and Blindness Council

Authority.—Established by law in August 1950 pursuant to section 431 of the Public Health Service Act (Public Law 410, 78th Cong.), as amended by Public Law 692, 81st Congress.

Structure.—Consists of the Surgeon General as Chairman, the chief medical officer of the Veterans' Administration or his representative, and a medical officer designated by the Secretary of Defense who serve as ex officio members; and 12 members appointed by the Surgeon General with approval of the Administrator who are leaders in the fields of fundamental sciences, medical sciences, education, or public affairs. Six of these members are leading medical or scientific authorities outstanding in the study, diagnosis, or treatment of neurological diseases and blindness. Members are appointed for overlapping terms of 4 years, and no member is eligible for reappointment within 1 year after the end of his preceding term.

Function.—Reviews applications for grants-in-aid relating to research projects in the field of neurological diseases and blindness, and recommends to the Surgeon General the approval of those projects which merit support. Consults with and advises the Suregon General on matters relating to neurological diseases and blindness.

Meetings.—Three meetings are held annually—usually in February, June, and October.

Member	Organization	Address
Scheele, Dr. Leonard A. (Chairman).[1]	Public Health Service	Washington, D. C.
Barnett, M. Robert (55)	American Foundation for the Blind, Inc.	15 West 16th St., New York, N. Y.
Barnett, W. Kuhn (54)	State Board of Education	Richmond, Va.
Boone, Vice Admiral Joel T.[1]	Veterans' Administration	Washington, D. C.
Casberg, Dr. Melvin A.[1]	Department of Defense	Do.
Geiger, Davis E. (55)	National Society for Crippled Children and Adults.	Ashland, Ky.
Hudson, Earl J. (56)	United Detroit Theatre Corp.	28 West Adams Ave., Detroit, Mich.
Kendell, Dr. H. Worley (55)	Institute of Physical Medicine and Rehabilitation.	619 North Glen Oak Ave., Peoria, Ill.
Merritt, Dr. H. Houston (53)	Neurological Institute	710 West 168th St., New York, N. Y.
Traeger, Dr. Cornelius H. (54)	National Multiple Sclerosis Society.	270 Park Ave., New York, N. Y.
Ulmer, J. M. (53)	Ulmer, Berne, Gordon & Glickman.	East 47th and Euclid Ave., Cleveland, Ohio.
Vail, Dr. Derrick (56)	Northwestern University	700 North Michigan Ave., Chicago, Ill.
Warren, Dr. Stafford L. (56)	University of California School of Medicine.	141 Tigertail Road, Los Angeles, Calif.
Woltman, Dr. Henry W. (54)	Mayo Clinic	Rochester, Minn.
Woolley, Dr. D. W. (53)	Rockefeller Institute	66th and York Ave., New York, N. Y.

[1] Ex officio.

BIOCHEMISTRY STUDY SECTION

Member	Organization	Address
Griffith, Dr. Wendell H. (53) (chairman).	University of California Medical Center.	Los Angeles, Calif.
Fuhr, Dr. Irvin (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Barker, Dr. H. A. (55)	University of California College of Agriculture.	3048 Life Security Bldg., Berkeley, Calif.
Brown, Dr. George B. (54)	Sloan-Kettering Institute	444 East 68th St., New York, N. Y.
Carter, Dr. H. E. (54)	University of Illinois	Urbana, Ill.
Cheldelin, Dr. Vernon H. (55)	Oregon State College	Corvallis, Oreg.
Duff, Col. Fratis L.	Air Force Headquarters, OSG	Washington, D. C.
Gurin, Dr. Samuel (55)	University of Pennsylvania School of Medicine.	Philadelphia, Pa.
Jensen, Dr. Hans F.	Army Medical Research Laboratory.	Fort Knox, Ky.
Irish, Dr. Oliver J.	Veterans' Administration, Pathology Division.	Washington, D. C.
Anfinsen, Dr. Christian B.	National Institutes of Health	Bethesda, Md.
Miller, Dr. James A. (55)	McCardle Memorial Laboratory, Wisconsin University.	Madison, Wis.
Ochoa, Dr. Severo (53)	New York University College of Medicine.	477 1st Ave., New York, N. Y.
Sendroy, Dr. Julius, Jr.	National Naval Medical Center	Bethesda, Md.
Smith, Dr. Emil L. (54)	University of Utah School of Medicine.	Salt Lake City, Utah.
Stotz, Dr. Elmer H. (54)	University of Rochester School of Medicine and Dentistry.	260 Crittenden Blvd., Rochester, N. Y.

CARDIOVASCULAR STUDY SECTION

Burch, Dr. George E. (53) (chairman).	Tulane University School of Medicine.	1430 Tulane Avenue, New Orleans, La.
Darby, Dr. Eleanor M. K. (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Butler, Dr. Allan M. (54)	Massachusetts General Hospital	Boston, Mass.
Dorfman, Dr. Albert (55)	University of Chicago School of Medicine.	920 East 59th St., Chicago, Ill.
Essex, Dr. Hiram (54)	Mayo Foundation	Rochester, Minn.
Grimson, Dr. Keith S. (55)	Duke University	Durham, N. C.
Hellman, Dr. Louis M. (56)	State University New York College of Medicine.	451 Clarkson Ave., Brooklyn, N. Y.
Lewis, Dr. John K. (53)	Stanford University Hospital	San Francisco, Calif.
Mattingly, Col. Thomas W.	Army Medical Center, Walter Reed Hospital.	Washington, D. C.
McGregor, Cmdr. J. B.	National Naval Medical Center	Bethesda, Md.
Preston, Col. William D.	Air Force Headquarters, OSG	Washington, D. C.
Stadie, Dr. W. C. (53)	University of Pennsylvania	36th and Spruce Sts., Philadelphia, Pa.
Terry, Dr. Luther L.	Public Health Service Hospital	Wyman Park Dr. and 31st St., Baltimore, Md.
Warren, Dr. James V. (55)	Duke University Medical School	Durham, N. C.
White, Dr. Harvey L. (55)	Washington University School of Medicine.	Kingshighway and Euclid Ave., St. Louis, Mo.
Thomson, Dr. K. Jefferson (56)	Metropolitan Life Insurance Co.	Madison Ave., New York, N. Y.

DENTAL STUDY SECTION

Appleton, Dr. J. L. T. (53) (chairman).	University of Pennsylvania School of Dentistry.	40th and Spruce Sts., Philadelphia, Pa.
Offutt, Dr. Edward P. (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Arnold, Dr. Francis A., Jr.	do	Do.
Bernier, Col. Joseph	Armed Forces Institute of Pathology.	7th St. and Independence Ave. SW., Washington, D. C.
Brodie, Dr. Allan G. (53)	University of Illinois College of Dentistry.	808 South Wood St., Chicago, Ill.
Elwell, Lt. Col. Kenneth R.	Air Force Headquarters, OSG	Washington, D. C.
English, Capt. James A.	National Naval Medical Center	Bethesda, Md.
Kreshover, Dr. Seymour J. (55)	Virginia Medical College, School of Dentistry.	Richmond, Va.
Pfeiffer, Dr. Kenneth R.	Veterans' Administration, Dental Service Division.	Washington, D. C.
Phillips, Prof. Ralph W. (55)	University of Indiana School of Dentistry.	1121 West Michigan Ave., Indianapolis, Ind.
Volker, Dr. J. F. (55)	University of Alabama School of Dentistry.	Birmingham, Ala.
Zander, Dr. H. A. (54)	University of Minnesota	Minneapolis, Minn.

[1] Ex officio.

ENDOCRINOLOGY STUDY SECTION

Member	Organization	Address
Huggins, Dr. Charles (54) (chairman).	University of Chicago	950 East 59th St., Chicago, Ill.
Hall, Dr. Samuel (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Alpert, Dr. Louis K	Veterans' Administration hospital	2650 Wisconsin Ave. NW., Washington, D. C.
Bennett, Dr. Leslie L. (55)	University of California School of Medicine.	Berkeley, Calif.
Gallagher, Dr. T. F. (54)	Sloan-Kettering Institute	444 East 68th St., New York, N. Y.
Grollman, Dr. Arthur (53)	Southwestern Medical College	2211 Oaklawn Ave., Dallas, Tex.
Groover, Lt. Col. Marshall E	Army dispensary	Pentagon Building, Washington, D. C.
Hertz, Dr. Roy	National Institutes of Health	Bethesda, Md.
Nelson, Dr. Warren O. (55)	University of Iowa State College of Medicine.	Iowa City, Iowa.
Pincus, Dr. Gregory (55)	Worcester Foundation for Applied Research.	Shrewsbury, Mass.
Ratcliffe, Lt. Col. H. E	Department of Army, OSG	Washington, D. C.
Russell, Dr. Jane A. (54)	Emory University School of Medicine.	Emory University, Ga.
Soskin, Dr. Samuel (53)		405 North Bedford Dr., Beverly Hills, Calif.
Thorn, Dr. George W. (55)	Peter Bent Brigham Hospital	Boston, Mass.
Vollmer, Dr. E. P	National Naval Medical Center	Bethesda, Md.

ENVIRONMENTAL HEALTH STUDY SECTION

Fair, Prof. Gordon (54) (chairman).	Harvard University	Dunster House, Cambridge, Mass.
Gerring, Irving (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Bishopp, Dr. F. C	Department of Agriculture, Bureau of Entomology and Plant Quarantine.	Washington D. C.
Carmichael, Lt. Col. Jack C	Air Force Headquarters, OSG	Do.
Chaffin, Comdr. Alexander N	Department of Navy	Potomac Annex, Washington, D. C.
Gotaas, Dr. Harold B. (53)	University of California	Berkeley, Calif.
Halverson, Dr. H. O. (54)	University of Illinois	Urbana, Ill.
Hatch, Theodore F. (56)	University of Pittsburgh Graduate School of Public Health.	Pittsburgh, Pa.
MacKenzie, Vernon G	Environmental Health Center	1006 Broadway, Cincinnati, Ohio.
Mallman, Dr. W. L. (55)	Michigan State College	Lansing, Mich.
Olson, Prof. Theodore A. (55)	University of Minnesota School of Public Health.	Minneapolis, Minn.
Princi, Dr. Frank (54)	University of Cincinnati College of Medicine.	Cincinnati, Ohio.
Renn, Dr. Charles E. (55)	Johns Hopkins University School of Engineering.	Baltimore, Md.
Weidenkopf, Lt. Col. Stanley J.	Department of Army, OSG	Washington, D. C.
Marks, Henry C. (56)	Wallace & Tiernan Co	Newark, N. J.

EXPERIMENTAL THERAPEUTICS STUDY SECTION

McDermott, Dr. Walsh (53) (chairman).	Cornell University Medical Center.	525 East 68th St., New York, N. Y.
Appel, Dr. Frederick W. (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Beeson, Dr. Paul (54)	Yale University School of Medicine.	789 Howard Ave., New Haven, Conn.
Berliner, Dr. Robert W	National Institutes of Health	Bethesda, Md.
Cromwell, Dr. Norman H. (56)	University of Nebraska	Lincoln, Nebr.
Gellhorn, Dr. Alfred (55)	Columbia University College of Physicians and Surgeons.	620 West 168th St., New York, N. Y.
Gordon, Dr. Harry H. (53)	Sinai Hospital of Baltimore	Monument and Rutland Sts., Baltimore, Md.
Hall, Dr. Byron E. (54)		809 Hyde St., San Francisco, Calif.
Knoblauch, Col. F. J	Department of Army, OSG	Washington, D. C.
Merrill, Dr. Malcolm H. (53)	California Department of Public Health.	2180 Milvia St., Berkeley, Calif.
Phillips, Comdr. Robert A	Department of Navy	Potomac Annex, Washington, D. C.
Skipper, Dr. Howard E. (55)	Southern Research Institute	917 South 20th St., Birmingham, Ala.
Smith, Lt. Col. Paul K	Air Force Headquarters, OSG	Washington, D. C.
Stock, Dr. C. Chester (53)	Sloan-Kettering Institute	410 East 68th St., New York, N. Y.
Walker, Dr. Arthur M	Veterans' Administration, Medicine and Surgery Department.	Washington, D. C.
Wilson, Dr. Julius L. (55)	Henry Phipps Institute	7th and Lombard Sts., Philadelphia, Pa.
Wood, Dr. W. Barry, Jr. (54)	Barnes Hospital	600 South Kingshighway, St. Louis, Mo.

[1] Ex-officio.

HEMATOLOGY STUDY SECTION

Member	Organization	Address
Moore, Dr. Carl V. (55) (chairman).	Barnes Hospital	600 South Kingshighway, St. Louis, Mo.
Brunstetter, Dr. Byron C. (executive secretary).[1]	National Institute of Health	Bethesda, Md.
Brecher, Dr. George	do	Do.
Chanutin, Dr. Alfred (55)	University of Virginia	Charlottsville, Va.
Conley, Dr. C. Lockard (56)	Johns Hopkins Hospital	Baltimore, Md.
Cronkite, Lt. Cmdr. E. P	National Naval Medical Center	Bethesda, Md.
Crosby, Col. William H	Army Medical Center, Walter Reed Hospital.	Washington, D. C.
Diamond, Dr. Louis K. (53)	The Children's Hospital	300 Longwood Ave., Boston, Mass.
Finch, Dr. Clement A. (56)	University of Washington School of Medicine.	Seattle, Wash
Gorley, Brig. Gen. Alvin L	Department of Defense, Office of Medical Services.	Washington, D. C.
Ham, Dr. Thomas Hale (55)	Western Reserve University School of Medicine.	2109 Adelbert Rd., Cleveland, Ohio.
Jacobson, Dr. Leon O. (54)	University of Chicago	Chicago, Ill.
Lawton, Col. Alfred H	Air Force Headquarters, OSG	Washington, D. C.
Strumia, Dr. Max M. (55)	Bryn Mawr Hospital	Bryn Mawr, Pa.

MENTAL HEALTH STUDY SECTION

Gildea, Dr. Edwin F. (53) (chairman).	Washington University School of Medicine.	St. Louis, Mo.
Eberhart, Dr. John C. (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Aird, Dr. Robert B. (54)	University of California Medical Center.	San Francisco, Calif.
Alden, Lt. Col. Carlos C., Jr	Air Force Headquarters	Washington, D. C.
Armstrong, Dr. S. Howard (54)	The Presbyterian Hospital	1753 West Congress St., Chicago Ill.
Benjamin, Dr. John (54)	University of Colorado School of Medicine.	4200 East 9th Ave., Denver, Colo.
Cottrell, Dr. Leonard S., Jr. (55)	Russell Sage Foundation	505 Park Ave., New York, N. Y.
Finesinger, Dr. Jacob E. (53)	University of Maryland Medical School.	Baltimore, Md.
Forster, Dr. Francis (55)	Georgetown University School of Medicine.	Washington, D. C.
Frank, Dr. Jerome D. (55)	Johns Hopkins Hospital	Baltimore, Md.
Harris, Dr. Robert E. (53)	University of California Medical Center.	San Francisco, Calif.
Hollingshead, Dr. A. B. (53)	Yale University	New Haven, Conn.
Jervis, Dr. George A. (53)	Letchworth Village	Thiells, N. Y.
Lindsley, Dr. Donald B. (54)	University of California	Los Angeles, Calif.
Samuels, Dr. Leo T. (55)	University of Utah College of Medicine.	Salt Lake City, Utah.
Sears, Dr. Robert R. (53)	Harvard University	Cambridge, Mass.
Thompson, Cmdr. S. V	Department of Navy, Bureau of Medicine and Surgery.	Washington, D. C.
Woolsey, Dr. Clinton N. (55)	University of Wisconsin Medical School.	Madison, Wis.
Yakovlev, Dr. Paul (54)	Harvard Medical School	25 Shattuck St., Boston, Mass.
Lidz, Dr. Theodore (56)	Yale University School of Medicine.	New Haven, Conn.

METABOLISM AND NUTRITION STUDY SECTION

Darby, Dr. William J. (53) (chairman).	Vanderbilt University School of Medicine.	Nashville, Tenn.
Keiles, Dr. Elsa Orent (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Alpert, Dr. Louis K	Veterans' Administration hospital	2650 Wisconsin Ave. NW., Washington, D. C.
Baumann, Dr. C. A. (55)	University of Wisconsin College of Agriculture.	Madison, Wis.
Bunim, Dr. Joseph J	National Institutes of Health	Bethesda, Md.
Friedemann, Dr. Theodore F	Medical Nutrition Laboratory (Army).	1849 West Pershing Rd., Chicago, Ill.
Jackson, Dr. Robert L. (54)	State University of Iowa	Iowa City, Iowa.
Jolliffe, Dr. Norman (54)	Department of Health	125 Worth St., New York, N. Y.
Kentmann, Dr. E. Henry (54)	University of Rochester School of Medicine and Dentistry.	260 Crittenden Blvd., Rochester, N. Y.
Lawton, Col. Alfred H	Air Force Headquarters, OSG	Washington, D. C.
Peters, Dr. John P. (53)	Yale University School of Medicine.	New Haven, Conn.
Ragan, Dr. Charles (55)	Columbia University College of Physicians and Surgeons.	620 West 168th St., New York, N. Y.

[1] Ex officio.

METABOLISM AND NUTRITION STUDY SECTION—Continued

Member	Organization	Address
Reifenstein, Dr. Edward C., Jr. (54)	Oklahoma Medical Research Institute and Hospital.	825 Northeast 13th St., Oklahoma City, Okla.
Reitz, Comdr. A. G	National Naval Medical Center	Bethesda, Md.
Ropes, Dr. Marian W. (53)	Massachusetts General Hospital	Boston, Mass.
Stare, Dr. Frederick J. (55)	Harvard University	Do.
Stetten, Dr. DeWitt (55)	Public Health Research Institute (NYC).	Foot of East 15th St., New York, N. Y.
Turner, Dr. Roy H. (56)	Tulane University School of Medicine.	1430 Tulane Ave., New Orleans, La.

MICROBIOLOGY AND IMMUNOLOGY STUDY SECTION

Turner, Dr. Thomas B. (54) (chairman).	Johns Hopkins University School of Hygiene and Public Health.	615 North Wolfe St., Baltimore, Md.
Offutt, Dr. Edward P. (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Barnes, Comdr. LaVerne A	National Naval Medical Center	Do.
Cummings, Dr. G. D. (56)	Michigan Department of Health	Lansing, Mich.
Duran-Reynals, Dr. F. (54)	Yale University School of Medicine.	310 Cedar St., New Haven, Conn.
Dyer, Dr. R. E. (55)	Robert Winship Memorial Clinic	Emory University, Ga.
Eagle, Dr. Harry	National Institutes of Health	Bethesda, Md.
Evans, Dr. Charles A. (55)	University of Washington	Seattle, Wash.
Gunsalus, Dr. I. C. (55)	University of Illinois	Urbana, Ill.
Lefton, Solomon E	Air Force Headquarters	Washington, D. C.
Hooker, Dr. Sanford B. (53)		Bradford, Conn.
Parr, Dr. Leland	Veterans' Administration, George Washington University.	1335 H St. NW., Washington, D. C.
Shaffer, Dr. Morris F. (53)	Tulane University School of Medicine.	New Orleans, La.
Sherman, Prof. James M. (55)	Cornell University	Ithaca, N. Y.
Warren, Dr. Joel	Army Medical Center	Washington, D. C.

MORPHOLOGY AND GENETICS STUDY SECTION

Wilson, Dr. J. Walter (54) (chairman).	Brown University	Providence, R. I.
Schmehl, Francis L. (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Butler, Dr. E. G. (55)	Princeton University	Princeton, N. J.
Copeland, Dr. Donald E	Air Force Headquarters, OSG	Washington, D. C.
Dempsey, Dr. Edward W. (55)	Washington University	St. Louis, Mo.
Flexner, Dr. Louis B. (55)	University of Pennsylvania School of Medicine.	Philadelphia, Pa.
Goddard, Dr. David R. (54)	University of Pennsylvania	38th and Woodland Ave., Philadelphia, Pa.
Heston, Dr. Walter E	National Institutes of Health	Bethesda, Md.
Kirschbaum, Dr. Arthur (55)	University of Illinois School of Medicine.	1853 West Polk St., Chicago, Ill.
Lehninger, Dr. A. L. (54)	Johns Hopkins University School of Medicine.	710 North Washington St., Baltimore, Md.
Pate, Lt. (jg.) James W	Naval Medical Research Institute	Bethesda, Md.
Schmitt, Dr. Francis O. (54)	Massachusetts Institute of Technology.	Cambridge, Mass.
Snyder, Dr. Laurence H. (56)	University of Oklahoma	Norman, Okla.
Stowell, Dr. Robert E. (53)	University of Kansas Medical Center.	Kansas City, Kans.
Tatum, Dr. El L. (53)	Stanford University School of Biological Science.	Stanford, Calif.
Tessmer, Lt. Col. Carl F	Army Medical Research Laboratory.	Fort Knox, Ky.

PATHOLOGY STUDY SECTION

Mortiz, Dr. Alan (54) (chairman).	Western Reserve University	2085 Adelbert Rd., Cleveland, Ohio.
Brunstetter, Dr. Byron C. (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Ash, Dr. J. E	Veterans' Administration	915 19th St. NW., Washington, D. C.
DeCoursey, Brig. Gen. Elbert	Armed Forces Institute of Pathology.	7th and Independence Ave. SW., Washington, D. C.
Farber, Dr. Sidney (54)	The Children's Hospital	300 Longwood Ave., Boston Mass.
Furth, Dr. Jacob (54)	Oak Ridge National Laboratory	Post Office Box P., Oak Ridge, Tenn.

[1] Ex officio.

PATHOLOGY STUDY SECTION—Continued

Member	Organization	Address
Hartman, Dr. Frank W. (53)	Henry Ford Hospital	Detroit, Mich.
Holman, Dr. Russell L. (53)	Louisiana State University School of Medicine.	New Orleans, La.
Klemperer, Dr. Paul	Mount Sinai Hospital	New York, N. Y.
Sprunt, Dr. Douglas H. (53)	University of Tennessee	Memphis, Tenn.
Stewart, Dr. Harold L	National Institutes of Health	Bethesda, Md.
Thompson, Col. Ralph M	Armed Forces Institute of Pathology.	7th and Independence Ave., SW., Washington, D. C.
Williams, Cmdr. R. B., Jr	National Naval Medical Center	Bethesda, Md.
Zimmerman, Dr. H. M. (55)	Montefiore Hospital	Gun Hill Rd. near Jerome Ave., New York, N. Y.
Baker, Dr. A. B. (56)	University of Minnesota Medical School.	Minneapolis, Minn.
Hass, Dr. G. M. (56)	Presbyterian Hospital	Chicago, Ill.

PHARMACOLOGY STUDY SECTION

Dragstedt, Dr. Carl A. (53) (Chairman).	Northwestern University Medical School.	303 East Chicago Ave., Chicago, Ill.
Keiles, Dr. Elsa Orent (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Chen, Dr. K. K. (55)	Lilly Research Laboratories	Indianapolis, Ind.
Ellinger, Dr. E. P	National Naval Medical Center	Bethesda, Md.
Gilman, Dr. Alfred (55)	Columbia University College of Physicians and Surgeons.	630 West 168th St., New York, N. Y.
Haag, Dr. Harvey B. (53)	Medical College of Virginia	Richmond, Va.
Johnson, Lt. Col. Hensley S	Department of Army, OSG	Washington, D. C.
Krantz, Dr. John C., Jr. (54)	University of Maryland	29 South Greene St., Baltimore, Md.
Krayer, Dr. Otto (54)	Harvard Medical School	25 Shattuck St., Boston, Mass.
Larnce, Lt. Col. Paul C	Air Force Headquarters, AFCSG	Washington, D. C.
Pfeiffer, Dr. Carl Curt (53)	University of Illinois College of Medicine.	1853 West Polk St., Chicago, Ill.
Rosenthal, Dr. Sanford M	National Institutes of Health	Bethesda, Md.
Welch, Dr. Arnold D. (55)	Western Reserve University	Cleveland, Ohio.
Comroe, Dr. Julius H. (56)	University of Pennsylvania	Philadelphia, Pa.

PHYSIOLOGY STUDY SECTION

Gray, Dr. John S. (55) (Chairman).	Northwestern University Medical School.	303 East Chicago Ave., Chicago, Ill.
Huttrer, Dr. Charles P. (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Brookhart, Dr. John M. (55)	University of Oregon Medical School.	Portland, Oreg.
Copeland, Dr. Donald E	Department of Air Force, OSG	Washington, D. C.
Daggs, Dr. Ray G	Medical Department, Field Research Laboratory.	Fort Knox, Ky.
Jones, Dr. Hardin B. (55)	University of California	Berkeley, Calif.
Lewis, Dr. Howard B. (53)	University of Michigan Medical School.	Ann Arbor, Mich.
Morales, Dr. Manual	Naval Medical Research Institute	Bethesda, Md.
Nunemaker, Dr. John C	Veterans' Administration, Research and Education Service.	Vermont Ave. and H St. NW., Washington, D. C.
Pitts, Dr. Robert F. (55)	Cornell University Medical College.	1300 York Ave., New York, N. Y.
Quigley, Dr. J. P. (53)	University of Tennessee	Memphis, Tenn.
Shock, Dr. Nathan W	Baltimore City Hospital (PHS project).	Baltimore, Md.
Solomon, Dr. Harry C. (54)		74 Fenwood Road, Boston, Mass.
Youmans, Dr. W. B. (56)	University of Wisconsin	Madison, Wis.

PUBLIC HEALTH STUDY SECTION

Buck, Dr. Carl (53) (chairman)	University of Michigan School of Public Health.	Ann Arbor, Mich.
Appel, Dr. Frederick W. (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Carpenter, Col. George R	Department of Army, OSG	Washington, D. C.
Clocco, Dr. Antonio (53)	University of Pittsburgh Graduate School of Public Health.	Pittsburgh, Pa.
Clark, Dr. Dean A. (54)	Massachusetts General Hospital	Boston, Mass.
Duff, Col. Fratis L	Department of Air Force (Division of Professional Research).	Washington, D. C.
Eller, Dr. C. Howe (55)	University of Louisville School of Medicine.	240 East Madison St., Louisville, Ky.

[1] Ex officio.

PUBLIC HEALTH STUDY SECTION—Continued

Member	Organization	Address
Johnson, Dr. Bascom	Veterans' Administration Hospital	Denver, Colo.
Muench, Dr. Hugo (54)	Harvard School of Public Health	55 Shattuck St., Boston, Mass.
Nahm, Dr. Helen (55)	National Nursing Accrediting Service.	2 Park Ave., New York, N. Y.
Perrott, George St. J	Public Health Service	Washington, D. C.
Rogers, Dr. Edward S. (54)	University of California School of Public Health.	Berkeley, Calif.
Sapero, Capt. J. J	Department of Navy, Bureau of Medicine and Surgery.	Potomac Annex, Washington D. C.
Vance, Dr. Rupert B. (54)	University of North Carolina	Chapel Hill, N. C.

SENSORY DISEASES STUDY SECTION

Friedenwald, Dr. Jonas S. (54) (chairman).	Johns Hopkins University	1212 Eutaw Pl., Baltimore, Md.
Huttrer, Dr. Charles P. (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Canfield, Dr. Norton (56)	Yale University School of Medicine.	175 St. Ronan St., New Haven, Conn.
Davis, Dr. Hallowell (54)	Central Institutes for the Deaf	818 South Kingshighway, St. Louis, Mo.
King, Col. John H., Jr	Army Medical Center, Walter Reed Hospital.	Washington, D. C.
Kinsey, Dr. V. Everett (53)	Kresge Eye Institute	690 Mullett St., Detroit, Mich.
Kronfeld, Dr. Peter (53)	University of Illinois School of Medicine.	904 West Adams St., Chicago, Ill.
Maxwell, Brig. Gen. Earl	Air Force Headquarters, OSG	Washington, D. C.
Ruch, Dr. Theodore C. (56)	University of Washington	Seattle, Wash.
Ryan, Capt. Stephen	Naval Medical Research Institute	Bethesda, Md.
Smelser, Dr. George K. (54)	Columbia University College of Physicians and Surgeons.	630 West 168th St., New York, N. Y.
Swan, Dr. Kenneth C. (53)	University of Oregon Medical School.	3181 Southwest Marquam Hill Rd., Portland, Oreg.
Thygeson, Dr. Phillips (55)	University of California Medical School.	Medical Center, San Francisco, Calif.

SURGERY STUDY SECTION

Wangensteen, Dr. Owen H. (54) (chairman).	University of Minnesota Medical School.	Minneapolis, Minn.
Ellis, Dr. J. Marshall (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Beck, Dr. Claude S. (54)	Lakeside Hospital	2065 Adelbert Rd., Cleveland, Ohio.
Brown, Capt. R. B	National Naval Medical Center	Bethesda, Md.
DeBakey, Dr. Michael E. (56)	Baylor University College of Medicine.	Houston, Tex.
Dragstedt, Dr. Lester R. (53)	University of Chicago Department of Surgery.	950 East 59th St., Chicago, Ill.
Dripps, Dr. Robert D. (55)	University of Pennsylvania	Philadelphia, Pa.
Elkin, Dr. Daniel C. (53)	Emory University Hospital	Emory University, Ga.
Gibbon, Dr. John H., Jr. (55)	Jefferson Medical College of Philadelphia.	1025 Walnut St., Philadelphia, Pa.
Harkins, Dr. Henry N. (55)	University of Washington School of Medicine.	Seattle, Wash.
Heinbecker, Dr. Peter (55)	Washington University School of Medicine.	St. Louis, Mo.
Hunt, Dr. G. Halsey	Public Health Service	Washington, D. C.
Ingraham, Dr. Franc D. (56)	The Children's Medical Center	300 West Longwood Ave., Boston Mass.
Lee, Dr. J. Gordon	Veterans' Administration Hospital.	2650 Wisconsin Ave. NW., Washington, D. C.
Mulholland, Dr. John H. (55)	New York University, Bellevue Medical Center.	477 1st Ave., New York, N. Y.
Wenger, Col. Don S	Air Force Headquarters	Washington, D. C.
Shaeffer, Col. Joseph R	Department of Army, OSG	Do.
Shumacker, Dr. Harris B., Jr. (54).	University of Indiana Medical Center.	1040–1232 West Michigan St, Indianapolis, Ind.

[1] Ex officio.

TROPICAL MEDICINE STUDY SECTION

Member	Organization	Address
Frye, Dr. William (55) (chairman).	Louisiana State University School of Medicine.	New Orleans, La.
Gerring, Irving (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Boyd, Dr. George H. (53)	University of Georgia Graduate School.	Athens, Ga.
Chandler, Dr. Asa C. (53)	Rice Institute	Houston, Tex.
Cox, Col. Wesley C	Army Industrial Hygiene Laboratory.	Edgewood Arsenal, Md.
Duff, Col. Fratis L	Air Force Headquarters, OSG	Washington, D. C.
Henderson, Mr. John M. (53)		Isle of Hope, R. F. D. 6, Savannah, Ga.
Huff, Dr. Clay G	National Naval Medical Center	Bethesda, Md.
Otero, Dr. P. Morales (53)		703 Fernandez Juncos Ave., Santurce, P. R.
Most, Dr. Harry (54)	New York University College of Medicine.	477 1st Ave., New York, N. Y.
Roeder, Dr. Kenneth D. (56)	Tufts College	Medford, Mass.
Simmons, Brig. Gen. James S	Harvard School of Public Health	55 Shattuck St., Boston, Mass.
Travis, Dr. B. V. (56)	Cornell University Agricultural Experiment Station.	Ithaca, N. Y.
Weller, Dr. Thomas H. (56)	The Children's Hospital	300 Longwood Ave., Boston, Mass.
Wright, Dr. Willard H	National Institutes of Health	Bethesda, Md.

VIRUS AND RICKETTSIAL STUDY SECTION

Lennette, Dr. Edwin H. (55) (chairman).	California State Department of Public Health.	1392 University Ave., Berkeley, Calif.
O'Brien, Dr. Thomas E. (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Cox, Dr. Herald R (55)	Lederle Laboratories	Pearl River, N. Y.
Dingle, Dr. John H. (53)	Western Reserve University School of Medicine.	Cleveland, Ohio.
Friedewald, Dr. William F. (53).		410 Medical Arts Bldg., Atlanta, Ga.
Habel, Dr. Karl	National Institutes of Health	Bethesda, Md.
Henle, Dr. Werner (55)	Children's Hospital of Philadelphia.	1740 Bainbridge St., Philadelphia, Pa.
Hilleman, Dr. Maurice R	Army Medical School	Washington, D. C.
Kingston, Commander James R.	National Naval Medical Center	Bethesda, Md.
Meyer, Dr. K. F. (55)	University of California Medical Center.	San Francisco, Calif.
Parr, Dr. Leland	Veterans' Administration, George Washington University.	1335 H St. NW., Washington, D. C.
Sabin, Dr. Albert B. (56)	The Children's Hospital Research Foundation.	Cincinnati, Ohio.
Shope, Dr. Richard E. (54)	Rockefeller Institute for Medical Research.	66th St. and York Ave., New York, N. Y.
Smith, Lt. Col. Paul K	Air Force Headquarters	Washington, D. C.
Syverton, Dr. Jerome T. (54)	University of Minnesota	Minneapolis, Minn.

[1] Ex officio.

COMMITTEE ON SECTIONAL RESEARCH IN MICROBIOLOGY

Authority.—Established administratively in September 1951 by joint action of the Division of Research Grants and the National Microbiological Institute.

Structure.—Consists of 18 outstanding scientists, expert in their particular areas of research and representing their respective geographic sections of the United States. Members are appointed by the Chief of the Division of Research Grants for an indefinite period.

Function.—Reviews applications for grants-in-aid relating to research projects for the development of (*a*) methods permitting faster and more accurate identification of disease agents and (*b*) better immunization and related procedures, and recommends to the Surgeon General (through the National Advisory Health Council) the approval of those projects which merit support.

Meetings.—Three meetings are held annually—usually in January, May, and September. Last meeting held in September 1952.

Member	Organization	Address
Dack, Dr. G. M. (chairman)	University of Chicago	5724 Ellis Ave., Chicago, Ill.
Schmehl, Francis L. (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Davis, Dr. Dorland J	do	Do.
Duff, Col. Fratis L	Department of Air Force (Division of Professional Research).	Washington, D. C.
Fox, Dr. John	Tulane University School of Medicine.	New Orleans, La.
Fothergill, Dr. L. D	Chemical Corps Biological Laboratories.	Camp Detrick, Md.
Francis, Dr. Thomas, Jr	University of Michigan School of Public Health.	Ann Arbor, Mich.
Gordon, Dr. Irving	New York State Health Department.	New Scotland Ave, Albany, N. Y.
Irons, Dr. J. V	Texas State Health Department	Austin, Tex.
Larson, Dr. C. L	Rocky Mountain Laboratory, Public Health Service.	Hamilton, Mont.
Lennette, Dr. E. H	California State Health Department.	1392 University Ave., Berkeley, Calif.
McKee, Dr. A. P	State University of Iowa, College of Medicine.	Iowa City, Iowa.
Owsley, Rear Adm. John Q	Office of Secretary of Defense, AFMPC.	Washington, D. C.
Schaeffer, Dr. Morris	Communicable Disease Center, Public Health Service.	Montgomery, Ala.
Schoening, Dr. H. W	Department of Agriculture, Bureau of Animal Industry.	Washington, D. C.
Snyder, Dr. John	Harvard School of Public Health	55 Shattuck St., Boston, Mass.
Whayne, Col. Tom F	Department of Army, OSG	Washington, D. C.
Woodward, Dr. Theodore E	University of Maryland Medical School.	Lombard and Greene Sts., Baltimore, Md.
Vacancy		

[1] Ex officio.

Cancer Control Committee

Authority.—Established administratively in January 1948 by the National Cancer Institute.

Structure.—Consists of 12 members appointed by the Surgeon General who are leaders in the fields of medical science most directly related to cancer (pathology, surgery, and radiology), epidemiology, and medical and public health education and a liaison representative for the American Cancer Society. Members are appointed for overlapping terms of 4 years and no member is eligible for reappointment for a period of 1 year after the end of his preceding term.

Function.—Reviews applications for grants-in-aid for cancer teaching programs and cancer control projects and recommends to the Surgeon General (through the National Advisory Cancer Council) approval of those projects which merit support. Consults with and advises the Surgeon General and staff members of the National Cancer Institute on matters relating to cancer control.

Meetings.—Three meetings are held annually—usually in January, May, and September. Last meeting held in October 1952.

Member	Organization	Address
Moore, Dr. Robert A. (55) (Chairman).	Washington University School of Medicine.	Euclid Ave. and Kingshighway, St. Louis, Mo.
Larsen, Dr. Donald C. (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Anderson, Dr. Gaylord W. (54)	University of Minnesota School of Public Health.	Minneapolis, Minn.
Batchelder, Dr. Walter E. (54)	American College of Surgeons	40 East Erie St., Chicago, Ill.
Branch, Dr. Charles F. (53)	Central Maine General Hospital	Lewiston, Maine.
Cameron, Dr. Charles S. (Liaison).	American Cancer Society, Inc	47 Beaver St., New York, N. Y.
Griswold, Dr. Matthew H. (55)	Connecticut State Department of Health.	Hartford, Conn.
Hilleboe, Dr. Herman E. (54)	New York State Department of Health.	Albany, N. Y.
Miller, Dr. Earl R. (55)	University of California Medical School.	San Francisco, Calif.
Williams, Dr. George Z. (53)	Medical College of Virginia	Richmond, Va.
Zimmerer, Dr. Edmund G. (53)	Iowa State Department of Health	Des Moines, Iowa.

[1] Ex officio.

Mental Health Training Committee

Authority.—Established administratively in August 1946 by the National Advisory Mental Health Council.

Structure.—Consists of leading educators in mental health organized and functioning through four subcommittees in their respective disciplines: Psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing. Members are appointed by the Director of the National Institute of Mental Health for overlapping terms of 4 years.

Function.—Advises the National Institute of Mental Health on policies for the training-grant program and makes recommendations to the Surgeon General (through the National Advisory Mental Health Council) with respect to applications from training centers for grants-in-aid for training programs in the mental-health field.

Meetings.—Meets once a year—usually in the spring. Last meeting held in March 1952.

Member	Organization	Address
Barton, Dr. Walter E. (53) (chairman).	Boston State Hospital	Boston, Mass.
Vestermark, Dr. Seymour (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Subcommittee on Clinical Psychology:		
Dennis, Dr. Wayne (56)	Brooklyn College	Brooklyn, N. Y.
Gill, Dr. Merton (54)	Yale University School of Medicine.	New Haven, Conn.
Mowrer, Dr. O. H. (55)	University of Illinois	Urbana, Ill.
Rainy, Dr. Victor (56)	University of Colorado	Boulder, Colo.
Shaffer, Dr. Laurance F. (55)	Columbia University Teachers College.	New York, N. Y.
Vacancy		
Subcommittee on Psychiatry:		
Brown, Dr. Warren T. (54) (chairman).	Baylor University College of Medicine.	Houston, Tex.
Brosin, Dr. Henry (56)	University of Pittsburgh	Pittsburgh, Pa.
Branch, Dr. C. H. Hardin (54).	Utah University College of Medicine.	Salt Lake City, Utah.
Heath, Dr. Robert G. (55)	Tulane University	New Orleans, La.
Huston, Dr. Paul E. (55)	State University of Iowa	Iowa City, Iowa.
Ross, Dr. Alexander T. (53)	University of Indiana Medical Center.	1040 West Michigan St., Indianapolis, Ind.
Senn, Dr. Milton J. E. (53)	Yale University	333 Cedar St., New Haven, Conn.
Subcommittee on Psychiatric Social Work:		
Tracy, Miss Anna Belle (53) (chairman).	Western Reserve University School of Applied Social Science.	Cleveland, Ohio.
Bernard, Dr. Viola (54)		930 5th Ave., New York, N. Y.
Garrett, Miss Annette (55)	Smith College School for Social Work.	Northampton, Mass.
Smalley, Miss Ruth (53)	University of Pennsylvania School of Social Work.	2410 Pine St., Philadelphia, Pa.
Szurek, Dr. Stanislaus (55)	The Langley Porter Clinic	San Francisco, Calif.
Johnson, Dr. Arlien (56)	University of Southern California	Los Angeles, Calif.
Subcommittee on Psychiatric Nursing:		
Peplau, Hildegard (54) (chairman).	Columbia University Teachers College.	New York, N. Y.
Frank, Sister Charles Marie (53).	Incarnate Word College	San Antonio, Tex.
Greenhill, Dr. Maurice H. (55).	University of Maryland School of Medicine.	Baltimore, Md.
Wolf, Miss Lulu K. (55)	University of California Medical Center.	Los Angeles, Calif.
von Bergen, Miss Ruth (56)	University of Minnesota School of Public Health.	Minneapolis, Minn.
Vacancy		

[1] Ex officio.

Mental Health Community Services Committee

Authority.—Established administratively in August 1946 by the National Advisory Mental Health Council.

Structure.—Consists of 15 outstanding medical and scientific authorities interested in the fields of mental and public health. Members are appointed by the Director of the National Institute of Mental Health for overlapping terms of 4 years. A chairman is elected by the members of the committee.

Function.—Reviews the activities of the community services program of the National Institute of Mental Health and makes recommendations to the Surgeon General (through the National Advisory Mental Health Council) on policies and future activities for the community services aspect of the mental health program.

Meetings.—Meets once a year—usually in the fall. Last meeting held in October 1952.

Member	Organization	Address
Lowry, Dr. James V. (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Barrett, Dr. Joseph E. (55)	Department of Mental Hygiene and Hospitals.	9 North 12th St., Richmond, Va.
Erickson, Dr. Harold M. (53)	Oregon State Board of Health	1022 Southwest 11th Ave., Portland, Oreg.
Ford, Lyman S. (54)	Community Chests and Councils of America.	155 East 44th St., New York, N. Y.
Gildea, Dr. Margaret C. L. (53)	Forty-Five Hundred West Pine Clinics.	4500 West Pine Blvd., St. Louis, Mo.
Greenhill, Dr. Maurice H. (55)	University of Maryland School of Medicine.	Baltimore, Md.
Hirschberg, Dr. J. Cotter (54)	The Menninger Foundation	Topeka, Kans.
Louttit, Dr. C. M. (53)	University of Illinois	Urbana, Ill.
Meiklejohn, Mrs. Helen E. (54)		1525 La Loma Ave., Berkeley, Calif.
Nyswander, Dr. Dorothy (53)	University of California School of Public Health.	Berkeley, Calif.
Olson, Dr. Willard C. (54)	University of Michigan School of Education.	Ann Arbor, Mich.
Taylor, Miss Margaret S. (55)	Department of Interior, Bureau of Indian Affairs.	Washington, D. C.

[1] Ex officio.

Committee on Radiation Studies

Authority.—Established administratively in April 1951 by joint action of the Division of Research Grants and the National Cancer Institute.

Structure.—Consists of 21 members outstanding in the fields of radiation, physiology, psychoneurology, and radiation physics. Members are appointed by the Surgeon General for an indefinite period.

Function.—Reviews applications for grants-in-aid relating to research projects in radiation biology and recommends to the Surgeon General (through the respective national advisory councils) the approval of those projects which merit support. Consults with and advises the Surgeon General and staff members of the National Cancer Institute on matters relating to radiation biology.

Meetings.—Three meetings are held annually—usually in January, May, and September. Last meeting held in September 1952.

Name	Organization	Address
Sterner, Dr. James H. (chairman).	Eastman Kodak Co	Rochester, N. Y.
Schmehl, Francis L. (executive secretary).[1]	National Institutes of Health	Bethesda, Md.
Brues, Dr. Austin M	Argonne National Laboratory	Chicago, Ill.
Cantril, Dr. Simeon	Swedish Hospital	1211 Marion St., Seattle, Wash.
Curtis, Dr. Howard J	Brookhaven National Laboratory	Long Island, N. Y.
Dowdy, Dr. Andrew H	University of California	Los Angeles, Calif.
Dunham, Dr. Charles L	Atomic Energy Commission	Washington, D. C.
Furth, Dr. Jacob	Oak Ridge National Laboratory	Post Office Box B, Oak Ridge, Tenn.
Harlow, Dr. Harry	University of Wisconsin	Madison, Wis.
Hartgering, Lt. Col. J. B	Armed Forces Special Weapons Project.	Post Office Box 2610, Washington, D. C.
Jacobsen, Dr. Carlyle F	State University of New York	Albany, N. Y.
Jacobson, Dr. Leon O	University of Chicago Division of Biological Sciences.	Chicago, Ill.
Loosli, Dr. Clayton G	University of Chicago	Do.
Lorenz, Dr. Egon	National Institutes of Health	Bethesda, Md.
Nickson, Dr. James J	Memorial Cancer Center	444 East 68th St., New York, N. Y.
Quigley, Dr. J. P	University of Tennessee	Memphis, Tenn.
Reynolds, Dr. O. E	Office of Naval Research	Washington, D. C.
Ruch, Dr. Theodore C	University of Washington	Seattle, Wash.
Snider, Dr. Ray S	Northwestern University Medical School.	Chicago, Ill.
Talbot, Col. John	Air Research and Development Command.	Post Office Box 1395, Baltimore, Md.
Trump, Dr. John G	Massachusetts Institute of Technology.	Cambridge, Mass.
Wendt, Dr. G. Richard	University of Rochester	Rochester, N. Y.

[1] Ex officio.

Water Pollution Control Advisory Board

Member	*Organization*
Hollis, Mark D. (Chairman)	Public Health Service
Meehean, Dr. C. Lloyd	Department of the Interior
Whipple, Col. William	Department of the Army
Peet, Herbert M	Department of Agriculture
Berrigan, T. A	Merrimack River Valley Sewerage Board
Chatters, Carl H	American Municipal Association
Danse, L. A	General Motors Corp.
Rawn, A. M	Los Angeles County Sanitation Districts
Shoemaker, Carl D	National Wildlife Federation
Veatch, N. T	Black & Veatch, consulting engineers

Association of State and Territorial Health Officers

Member	Organization	State
Scheele, Dr. Leonard A. (chairman)	Public Health Service	Washington, D. C.
Gill, Dr. D. G	State Department of Health	Alabama.
Salsbury, Dr. Clarence G	State Department of Public Health	Arizona.
Herron, Dr. J. T	State Board of Health	Arkansas.
Halverson, Dr. Wilton L	State Department of Public Health	California.
Cleere, Dr. R. L	do	Colorado.
Osborn, Dr. Stanley H	State Department of Health	Connecticut.
Hudson, Dr. F. I	State Board of Health	Delaware.
Seckinger, Dr. Daniel L	District of Columbia Health Department	District of Columbia.
Sowder, Dr. Wilson T	State Board of Health	Florida.
Sellers, Dr. T. F	Department of Public Health	Georgia.
Peterson, L. J	do	Idaho.
Cross, Dr. Roland R	do	Illinois.
Burney, Dr. L. E	State Board of Health	Indiana.
Bierring, Dr. Walter L	State Department of Health	Iowa.
Hood, Dr. Thomas R	State Board of Health	Kansas.
Underwood, Dr. Bruce	State Department of Health	Kentucky.
Phillips, Dr. S. J	do	Louisiana.
Stevens, David H	Department of Health and Welfare	Maine.
Riley, Dr. Robert H	State Department of Health	Maryland.
Getting, Dr. Vlado A	Department of Public Health	Massachusetts.
Heustis, Dr. Albert E	Department of Health	Michigan.
Chesley, Dr. A. J	do	Minnesota.
Underwood, Dr. Felix J	State Board of Health	Mississippi.
Amos, Dr. James R	Department of Public Health and Welfare	Missouri.
Thompson, Dr. Carlyle G. D	State Board of Health	Montana.
Rogers, Dr. E. A	Department of Health	Nebraska.
Hurley, Dr. Daniel J	State Department of Health	Nevada.
Wheeler, Dr. John Samuel	State Health Department	New Hampshire.
Bergsma, Dr. Daniel	State Department of Health	New Jersey.
Scott, Dr. James R	Department of Public Health	New Mexico.
Hilleboe, Dr. Herman E	State Department of Health	New York.
Norton, Dr. J. W. R	State Board of Health	North Carolina.
Saxvik, Dr. Russel O	State Department of Health	North Dakota.
Porterfield, Dr. John D	Department of Health	Ohio.
Mathews, Dr. Grady F	State Department of Health	Oklahoma.
Erickson, Dr. Harold M	State Board of Health	Oregon.
Teague, Dr. Russel E	Department of Health	Pennsylvania.
McLaughlin, Dr. Edward A	do	Rhode Island.
Wyman, Dr. Ben F	State Board of Health	South Carolina.
Van Heuvelen, Dr. G. J	State Department of Health	South Dakota.
Hutcheson, Dr. R. H	Department of Public Health	Tennessee.
Cox, Dr. George W	State Department of Health	Texas.
Spendlove, Dr. George A	do	Utah.
Aiken, Dr. Robert B	Department of Health	Vermont.
Shanholtz, Dr. Mack I	do	Virginia.
Kahl, Dr. John A	State Department of Health	Washington.
Dyer, Dr. N. H	do	West Virginia.
Neupert, Dr. Carl N	State Board of Health	Wisconsin.
Yoder, Dr. Franklin D	State Department of Public Health	Wyoming.
Albrecht, Dr. C. Earl	Alaska Department of Health	Alaska.
Wilbar, Dr. C. L., Jr	Hawaii Department of Health	Hawaii.
Pons, Dr. Juan A	Puerto Rico Department of Health	Puerto Rico.
Anduze, Dr. Roy A	Virgin Islands Department of Health	Virgin Islands.

FEDERAL HOSPITAL COUNCIL

Member	*Affiliation*
Mr. Eugene Butler	Vice president and editor of Progressive Farmer.
Mr. Frank Fernbach	Associate director of research, Congress of Industrial Organizations.
Msgr. Donald A. McGowan	Director, Bureau of Health and Hospitals, National Catholic Welfare Conference.
Dr. Albert W. Snoke	Director, Grace-New Haven Hospital, New Haven, Conn.
Mrs. Helen J. Claytor	Member, National Board of Young Women's Christian Association.
Mrs. Evelyn Hicks Shannon	Former executive, Station WSGN, Birmingham, Ala.
Dr. Anthony J. J. Rourke	Executive secretary, Hospital Council of Greater New York.

STUDY SECTIONS

Dr. SCHEELE. May I add an additional thing on the study sections which the chairman asked about? Because of the range of problems handled by a given council—and they cover a vast area of basic biological and other interests—we have felt the need, and the council felt that they required, to have the support and opinion of highly specialized people. So we have approximately 18 or 19 groups of 10 or 12 men who are very highly specialized in the study sections in fields like endocrinology and a variety of similar specialized fields. They are the initial screeners. It may go to one study section, or several for an opinion if it is a broader project covering several activities. This is a device to assure that the opinion of the highest level of scientific minds is sought on each of these projects before a determination is made.

DISAPPROVAL OF RESEARCH PROJECT GRANTS BY SURGEON GENERAL

Mr. BUSBEY. Has there ever been an occasion in which the Surgeon General did not accept the advice of the council and thereby did not approve the grant?

Dr. SCHEELE. Yes. I believe there have been three. I would like to correct that if I am in error. (The corrected number is five.)

To give you a typical example, on one occasion we were asked for support from a university. In this case the University of Illinois wished to build a high-voltage generator, called a betatron, for experimental use. At the time the application came to us there were few sources for the kind of support that such a device would require. I am not sure of the amount now. I think it was something like $80,000 or $90,000 that they were asking for. At the time that the council considered this it seemed to be an appropriate area of research and the council recommended that the project be supported. However, we learned that the Atomic Energy Commission, at that time and at that very moment, had funds earmarked by the Congress in its appropriation, so that $5,000,000 of its research funds were to be devoted to cancer research, and the Atomic Energy Commission was going to embark on a program of supporting four or five such installations in the United States. Then, looking over the advice and the findings of a committee on high energy radiation which had been assembled in the Cancer Institute to look into the whole question of how far we should

go in supporting research in this very costly area, and what end results one might reasonably expect to achieve, it became apparent that this type of activity was going to be quite adequately covered by the Atomic Energy Commission's program, so it was determined that the Public Health Service could not reasonably support the project.

The other cases were similar type problems, as I recall. Dr. Sebrell may tell how many grants we have given, perhaps 1,500 grants in that time.

Dr. SEBRELL. Somewhere in that neighborhood.

SELECTION OF MEMBERS OF STUDY SECTIONS

Mr. BUSBEY. How are the members of the study sections selected?

Dr. SCHEELE. The members of the study sections are selected by having our Institutes chiefs and the various technical staff members of the Institutes, and the National Institutes of Health generally, look for individuals who they know through their scientific contacts in the scientific world, and recommend to Dr. Sebrell, and through Dr. Sebrell to me, as their selections to serve on these study sections. Obviously, in this process of selecting appropriate people, and we do have occasion—and this is done at the scientist level—to seek the advice of fellow scientists out in private life on who is the top-level man in a certain phase of science. By and large, through one scientist knowing other scientists in his field, we have pretty good knowledge of the leaders in the country in each field. It is by that sort of process that we arrive at the names of the men and then we send out our invitations for them to serve.

PAYMENT OF MEMBERS

Mr. BUSBEY. Are the members of the study sections paid out of the Public Health Service funds?

Dr. SCHEELE. Yes; they are paid their traveling expenses at the standard per diem rate and first-class transportation and in addition they receive probably about $42 a day while serving. It is the consultant rate paid at the grade GS–15 salary level. We are doing in this the identical thing the various other bodies in the field using scientific advisers are doing.

RELATIONSHIP OF WORK TO PROGRAMS OF PRIVATE HEALTH ORGANIZATIONS

Mr. BUSBEY. I notice at the top of page 7 of your prepared statement that you say:

> We also work closely with national voluntary health organizations such as the American Cancer Society, the American Heart Association, and the Arthritis and Rheumatism Foundation and many others, so that our research and training programs are integrated closely with those which they sponsor.

How do you avoid duplication in those programs?

Dr. SCHEELE. By the exchange of information and by the intimate contacts we have between members of our staff and their staffs. For example, in the case of cancer, the American Society conducts its research grant-in-aid program through the National Research Council. It provides money to them, something in excess of $3 million a year, to spend for cancer research, and they have in the National Research

Council a group of advisers who parallel our Council and our study sections. We exchange information on grant applications with the National Research Council, in this case, in cancer. We have an additional amount of information on the project applications, on the man who is wanting the assistance in addition, so we can tell whether he is asking for funds from someone else. We also have an indication of the previous support that he has had. We both place information on grants in an office in the National Research Council where there is collation of the activities of the whole field, at least from everyone who is willing to cooperate, and we provide a grant to the National Research Council along with the military services and the Atomic Energy Commission and others of the voluntary agencies outside to help provide this central clearinghouse for information on research projects and research grants.

Again staying in the cancer field, members of the Cancer Institute staff sit with the Committee on Growth, which is equivalent of our National Advisory Council. The members of the Committee on Growth and the American Cancer Society, usually its managing director, Mr. Mefford Runyon, sit with our National Advisory Council when it is in session.

Members of our staff, of course, visit their office frequently and they visit ours, and by this device we have a degree of coordination with them that I am exceedingly proud of.

OPENING OF NEW CLINICAL CENTER

Mr. BUSBEY. I noticed you mentioned in referring to the clinical center at the National Institutes of Health that you expect to receive the first patient in the near future.

Last year when this committee had under consideration the appropriation for the fiscal year 1953, I believe it was estimated that the first patients would be received during the first 2 weeks of April of this year.

Dr. SCHEELE. That is correct.

Mr. BUSBEY. What is the situation at the present time?

Dr. SCHEELE. At the present time the budget for 1954 is being reviewed and the activities in the Clinical Center for 1954 are being reviewed and restudied. The date on which we will accept our first patient in 1953, this current fiscal year, is still under consideration. It would seem likely now that we will not be taking our first patients in April. It will take us approximately 45 to 60 days after the determination is made on the actual opening date to get ready to actually receive the first patients, so obviously we will not be ready by April 1, as we had hoped to be at an earlier time. We are still hopeful that we will be able to open the center by June 1, or some such date.

DELAY IN ACQUISITION OF PERSONNEL

Mr. BUSBEY. I noticed an article in one of the Washington papers this morning. Unfortunately, I do not have it with me. As I recall it, it made some mention that there had been a delay in recruiting the personnel for the Clinical Center due to the uncertainty of the 1954 appropriation.

What effect has that had on the recruitment of personnel to operate the hospital?

Dr. SCHEELE. I think the principal effect is merely one of delay, the delay of recruitment. In other words, as soon as we have our firm dates fixed, we can proceed immediately then to put the schedule in that has been prepared for acquisition of personnel, and move forward.

Mr. BUSBEY. There is not any question in your mind that action Congress has taken on appropriations may have caused a delay in the hiring of the personnel necessary for the opening of the hospital, is there?

Dr. SCHEELE. Not as far as the appropriation by the Congress is concerned. In our case, this is a part of the review process of the 1954 budget, which is currently under way in the Federal Security Agency and the Bureau of the Budget, and until we are told what we may expect to spend in terms of actual calling for the money, or actually obligating the Government in hiring additional personnel, we are just standing by.

COST OF CONSTRUCTING AND EQUIPPING CLINICAL CENTER

Mr. BUSBEY. What has been the total cost of this center?

Dr. SEBRELL. The approximate cost of it, the construction of the Clinical Center, is in the vicinity of $40 million.

Mr. BUSBEY. Does that include the equipment?

Dr. SEBRELL. That includes the equipment of the Center, but not the complete development of the grounds and the auxiliary things. That would add another $20 million. The total cost in connection with this is about $60 million.

Mr. BUSBEY. That includes the main building and everything in connection with the Clinical Center?

Dr. SEBRELL. Absolutely everything.

RECRUITMENT OF PERSONNEL

Mr. BUSBEY. It is just inconceivable to me that we should spend $60 million on a clinical center and not supply the funds with which to staff and operate it. I do not quite understand why there should be any delay in staffing the center beyond the date the construction work was completed and it is ready for occupancy.

Dr. SCHEELE. In this case it is related to a restudy of the level at which the center should operate in 1954, and then trying to build 1953 into phase with that.

Mr. BUSBEY. You are certainly going to require a certain amount of personnel.

Dr. SCHEELE. Yes.

Mr. BUSBEY. What has been done to date to recruit that personnel?

Dr. SEBRELL. We have recruited some personnel. We were shooting for the April opening day, as was indicated last year to this committee, everything was going along on schedule, and we were making our preparations to employ the necessary personnel when the current restrictions on expenditures for this period made it necessary that we stop and review the present hiring situation in the light of where we were going to operate during 1954. It would be foolish to take on people now and have to discharge them the 1st of July, so the holdup is purely a matter of reevaluating the program in the

light of how large a development it is going to be in the course of the next fiscal year.

Mr. BUSBEY. Well, the delay in opening the Clinical Center is not due to any action of the Congress or the Appropriations Committee?

Dr. SEBRELL. No, sir.

Mr. FOGARTY. I think what should be brought out is that there was a directive issued in January by the Bureau of the Budget about hiring personnel. Does that have anything to do with this?

Dr. SCHEELE. Yes. A directive was received from the Bureau of the Budget to the effect we could not spend in any remaining months of the fiscal year 1953, under any of our appropriations, an amount in excess of our callup rate for January. In the case of the Clinical Center, we have had very little, if any, callup in January, because our opening date was to be April and we would begin our more intensive hiring only about 60 days before that. So we had no base from which to operate.

In addition, that same order indicated that we would not hire personnel to fill positions that were not filled before, or to hire personnel to fill positions going vacant, though it did provide that we might fill positions by transfer. Mr. Stephens might wish to extend this further on behalf of the agency.

Mr. STEPHENS. We had such a letter. It had two factors that affected this, or at least in our opinion did. One was not hiring any personnel, or filling any positions. The other was not exceeding the January rate. There was a provision in that letter, at least we thought so, where the Administrator, after complete justification, could waive that part of it. The Public Health Service wrote a memorandum asking about this recruiting of personnel. The agency immediately or within a few days, advised the Public Health Service to go ahead up to the number contemplated in their 1953 budget. Our interpretation of the Bureau of the Budget's letter was that we make such decisions and report the matter to the Budget Bureau. We did just that. We got a letter back from the Bureau of the Budget saying not to do that. That put us over a barrel. Nobody in the agency wanted to delay the opening of that Center for one moment. I personally thought that it was bad business to delay it, like I am sure the chairman does, but in the light of the letter we got back from the Bureau of the Budget, holding this up for future study, put sort of a crimp on the immediate opening of the Center.

Now, some developments in the opening of the Center have indicated that perhaps a little delay was wise, because most of the people whom they will secure probably have commitments that will run them through sometime in May, and maybe as far as the 1st of June, men already employed in universities and hospitals, and I think Dr. Scheele and Dr. Sebrell took that into consideration in moving that date back sometime in May and June because the desirable people are already committed.

Now, they will have to make commitments or these people will have secured other employment, or stay in their present positions. It is unfortunate that we got caught in the squeeze. We thought when we reported to the Director of the Budget the agency would interpose no restrictions or restraints on opening the Center as soon as it was ready,

and our waiver of the hiring to the Public Health Service indicated just that. But when we got the letter back indicating that there might be some drastic action on the 1954 budget, we were more or less stymied for the time being.

Mr. BUSBEY. Mr. Fogarty is better qualified to speak on what I am going to mention than I because he has been a member of this committee for many years and was the chairman of it for the past 4 years. I do know for a fact that this committee, both under the chairmanship of Mr. Frank Keefe of Wisconsin during the 80th Congress and of Mr. Fogarty during the 81st and 82d Congress, has had a very vital, sincere interest in this clinical center at Bethesda, and I know that somebody is going to come up some day and accuse this committee, or the Congress, of delaying the opening of the center in some way or other. I just want the record to show that it certainly was not the fault of this subcommittee on appropriations, or the Congress, that it is not being opened on schedule.

Dr. SCHEELE. You certainly can show that because none of this that has happened is related to any action that Congress has taken. I should like to add that all in the Public Health Service are very disappointed that we have not been able to go forward on schedule.

EXPENDITURES AND ADDITIONS TO FUNCTIONS OF PUBLIC HEALTH SERVICE, 1945–54

Mr. BUSBEY. In order that we may get some idea of the growth of the United States Public Health Service's activities during the last 10 years, would it be possible to have prepared for the record a table showing the total amounts spent each year for the period 1945 through the estimate for 1953 and 1954, subdivided into the following categories: medical research grants, research construction grants, nonresearch grants (excluding hospital construction grants), hospital construction grants, Public Health Service capital outlay, direct research, direct medical care, technical services, law enforcement, and any miscellaneous items that may not fall in these categories.

Dr. SCHEELE. That may be prepared, and we will furnish it to you.

Mr. FOGARTY. Over a period of 10 years?

Dr. SCHEELE. Yes.

Mr. FOGARTY. Would it not be well also to include in that table a record of the bills that have been passed by the Congress during that period? I am thinking about the establishment of the Heart Institute and the two new Institutes in Neurology and Blindness Activities and Arthritis and Metabolic Diseases, the Hospital Construction Act, and other legislation that has affected their growth.

Mr. BUSBEY. I see no objection. I think it would be helpful to the overall picture.

Dr. SCHEELE. It would show the new jobs that have been given the Public Health Service and why the additional sums were appropriated.

Mr. BUSBEY. Without objection those tables will be inserted in the record at this point.

(The tables referred to are as follows:)

Public Health Service appropriations, 1945 to 1953, inclusive, and original budget 1954

[In thousands of dollars]

	Medical research grants	Nonresearch grants, excluding hospitals	Hospital construction grants	Research construction grants	Public Health Service capital outlay	Direct medical care	Technical services	Law enforcement	Direct research	Other	Total
1945	123	84,383	0	0	0	17,370	17,306	1,534	2,360	4,648	127,724
1946	1,040	89,039	0	0	0	20,184	20,192	1,901	2,778	7,170	142,304
1947	3,711	54,052	0	0	0	20,597	12,552	2,108	4,425	8,070	105,515
1948	11,420	45,681	75,000	2,303	2,650	22,678	12,994	2,589	7,584	9,948	192,847
1949	14,871	44,035	75,000	8,000	30,630	26,752	18,412	3,336	10,961	7,452	239,449
1950	17,582	52,961	150,000	12,059	16,900	28,360	18,792	3,308	13,018	8,381	321,361
1951	18,922	44,161	85,000	0	8,175	29,024	19,061	3,214	13,810	7,502	228,869
1952	20,840	44,837	82,500	0	7,035	31,546	18,959	3,274	14,774	7,577	231,342
1953	23,209	43,298	75,000	0	300	33,188	18,396	3,294	17,639	7,283	221,607
1954	29,956	44,201	75,000	15,000	0	33,952	17,901	3,329	21,211	7,539	248,089

NOTE.—Statement includes contract authorizations but excludes amounts appropriated to liquidate contract authorizations.

PUBLIC HEALTH LEGISLATION INVOLVING ADDITIONAL APPROPRIATIONS, FISCAL YEAR 1945 TO DATE

July 3, 1946—National Mental Health Act, Public Law 487, 79th Congress.
Aug. 8, 1946—Health programs for Government employees, Public Law 658, 79th Congress.
Aug. 13, 1946—Hospital Survey and Construction Act, Public Law 725, 79th Congress.
June 16, 1948—National Heart Act, Public Law 655, 80th Congress.
June 24, 1948—National Dental Research Act, Public Law 755, 80th Congress.
June 30, 1948—Water Pollution Control Act, Public Law 845, 80th Congress.
Oct. 25, 1949—Hospital Survey and Construction Amendments of 1949, Public Law 380, 81st Congress.
Aug. 15, 1950—Support of research and training in matters relating to arthritis and rheumatism, multiple sclerosis, cerebral palsy, epilepsy, poliomyelitis, blindness, leprosy, and other diseases, Public Law 692, 81st Congress.
June 25, 1952—Care and treatment of persons afflicted with leprosy in Hawaii, Public Law 411, 82d Congress.

Dr. SCHEELE. This book [indicating] I have answers, in a very crude way, your question. I will say to the new members of the committee that you will find in this book about as simple a thumbnail sketch of the Public Health Service's activities as you will find in any place.

STATE HEALTH AGENCY FUNDS, 1943–52

Mr. BUSBEY. Thank you, Dr. Scheele. I am sure that this book will be of great interest to the committee.

How have State health department appropriations increased during the past 10 years? Do you have any actual figures that will show this?

Dr. SCHEELE. We do not have them with us today. We are prepared to furnish those to the committee.

(The material referred to follows:)

Federal grants and State and local funds for health services 1943 to 1952, inclusive

Program and source of funds [1]	1943	1944	1945	1946	1947	1948	1949	1950	1951	1952
General Health:										
Federal	$11,000,000	$11,000,000	$11,000,000	$11,000,000	$14,250,000	$11,217,039	$11,214,666	$14,200,000	$13,540,500	$13,500,000
State and local	55,603,810	63,037,218	64,691,315	71,288,195	83,012,634	94,442,640	97,359,206	128,525,829	129,790,810	140,319,680
Venereal disease control:										
Federal [2]	9,998,099	9,431,257	9,253,883	14,047,876	14,872,990	15,831,646	14,846,404	13,095,000	10,705,600	9,449,300
State and local [3]	7,519,836	9,300,275	11,736,582	11,330,194	12,677,417	14,163,659	16,824,364	16,233,518	14,644,653	15,624,209
Tuberculosis control:										
Federal			[4] 1,370,114	5,200,000	6,880,000	6,790,000	6,790,000	6,790,000	6,350,000	5,800,000
State and local:										
Preventive [5]			1,432,018	6,599,009	11,599,710	18,943,776	13,216,848	17,000,259	16,244,944	18,845,314
Hospital care [5]			25,330,054	35,131,930	41,783,919	55,425,652	78,490,115	85,652,844	120,904,458	125,318,257
Mental health:										
Federal						3,000,000	3,550,000	3,550,000	3,200,000	3,100,000
State and local [3]						3,226,009	6,248,550	6,590,720	7,819,218	7,611,043
Cancer control:										
Federal						2,500,000	2,500,000	3,500,000	3,200,000	3,100,000
State and local [3]						4,585,714	6,383,425	13,002,108	11,145,920	10,237,715
Heart disease control:										
Federal								2,000,000	1,700,000	1,500,000
State and local [3]								2,797,438	2,963,493	3,944,251
Industrial waste studies:										
Federal [6]								1,000,000	1,000,000	900,000
State [6]								1,560,683	2,645,698	2,944,099
Hospital survey and planning:										
Federal					[7] 1,800,000					
State and local [3]					554,647	1,121,974	782,283	631,492	572,338	336,840
Hospital construction:										
Federal:										
Obligational authority [8]						75,000,000	75,000,000	150,000,000	85,000,000	82,500,000
Liquidating cash						15,000,000	40,000,000	40,000,000	100,000,000	100,000,000
Sponsors share						209,630,363	201,752,759	296,029,045	156,151,362	121,276,476
Alaska grant:										
Federal							779,500	767,117	694,000	630,000
State and local [9]										

[1] Source: State and local funds obtained from reports submitted to the Public Health Service by State agencies participating in the Federal grants. Local funds are reported only for those jurisdictions which received aid from State health departments. Identifiable amounts for general hospital care and for construction (except for the hospital construction program) have been excluded.

[2] Beginning with 1946, amounts include grants (cash, services and supplies) for rapid treatment facilities approved on a project basis. For comparability from year to year, amounts for direct operation of centers have also been included.

[3] Includes estimates of generalized services contributed to the specialized program.

[4] Federal funds available for a 2-month period beginning May 1, 1945.

[5] These amounts do not represent national expenditures for tuberculosis hospital care since reports upon which these amounts are based are incomplete.

[6] These amounts are estimates of total water pollution control program. Estimates for industrial waste studies only are not available for all years shown. No information available for local expenditures.

[7] Appropriated and allotted to States in 1947; balances available thereafter until expended.

[8] Amounts for 1948, 1949, and 1950 and $75,000,000 of 1951, represent contract authorization for which liquidating cash is made available in subsequent years.

[9] Included in the general health program.

Dr. SCHEELE. I can tell you the end point last year. The State health departments' appropriations were approximately $200 million compared to $38 million through the Public Health Service. The State appropriations, until recent years at least, have been far exceeding the Federal appropriations.

PRIVATE CONTRIBUTIONS TO HEALTH ACTIVITIES

Mr. BUSBEY. We all know contributions in this field are made by private individuals, foundations, and organizations, and they have increased enormously, but are there actual figures available on such contributions?

Dr. SCHEELE. There are figures on the foundations that publish reports and the ones that have subscription drives where they approach the public for funds. They are available and we will furnish those to the committee.

Mr. BUSBEY. Without objection they will be inserted in the record at this point.

(The information requested is as follows:)

Research funds raised by voluntary health agencies interested in specific diseases [1]

	Research funds	
	1949	1950
American Cancer Society	$3,399,165	$3,842,982
American Foundation for the Blind	133,541	30,766
National Council to Combat Blindness	11,344	17,750
National Society for Prevention of Blindness	27,278	26,074
American Diabetes Association	None	1,953
American Heart Association	[2] 700,000	900,000
Arthritis and Rheumatism Foundation	99,661	225,630
Muscular Dystrophy Association of America		19,000
National Association for Mental Health (ex-National Committee for Mental Hygiene)	56,656	42,426
National Foundation for Infantile Paralysis	1,734,065	2,300,658
National Multiple Sclerosis Society	118,871	76,272
National Society for Crippled Children and Adults	100,000	115,475
National TB Association (National and States)	116,693	209,600
Planned Parenthood Federation of America	37,761	12,388
United Cerebral Palsy (ex-Cerebral Palsy Society of New York)	19,700	80,000
Total	6,554,735	7,900,974

[1] Excludes all other research funds provided from private non-industrial sources.
[2] For 6 months only.

NOTE.—These figures were abstracted from the Congressional Record, 82d Congress, 2d Session, vol. 98, No. 81, May 13, 1952, p. A3052.

FELLOWSHIP-AWARD PROGRAM

Mr. BUSBEY. I do not believe you mentioned your fellowship-award program. Would you explain that for the benefit of the committee and tell us how much you are spending on it?

Dr. SCHEELE. The followship program was created initially in the National Cancer Institute Act in 1937. It was then spread across the other institutes and Public Health Service as the individual institute acts were passed, and later when the so-called omnibus institute act was passed, which made uniform the basis for operation of heart, cancer, and all the rest.

In this particular program, in 1954, the proposal is to assist young men and women who wish to be trained in the so-called postdoctoral

area, after they receive their initial degrees and their higher degrees, the doctor of philosophy and the M. D., to receive additional training to work under the supervision of preceptors in our universities. In this program we are supporting something like 600-plus fellows. We can furnish the exact figure and the exact cost.

(The material requested is as follows:)

Statement of Research Fellowships

Appropriation	Obligations, 1953	Number
Operating expenses, National Institutes of Health	$199,000	63
Salaries, expenses, and grants, National Cancer Institute	625,000	178
Mental health activities	250,000	74
Salaries, expenses, and grants, National Heart Institute	450,000	130
Dental health activities	50,000	14
Arthritis and metabolic disease activities	150,000	38
Microbiology activities	150,000	45
Neurology and blindness activities	150,000	36
Total obligations for fellowships, 1953, and number of awards	2,204,000	578

TRANSFER OF PREDOCTORAL FELLOWSHIP PROGRAM

Dr. SCHEELE. In our request for 1954, $300,000 of the 1953 base has been transferred to the Science Foundation so that they will conduct a program which we were formerly conducting, namely, the granting of fellowships at the predoctoral level. We will operate only at the postdoctoral level in the 1954 period.

These men do not work for the Government, although they may seek Government employment later. Most of them have had their training in non-Government institutions, although when a particular Government institution offers, as far as an individual is concerned, the best opportunity for training because of the qualifications of the scientists there, they may take their fellowship training in a Government institution.

NEW DRUGS FOR TREATMENT OF TUBERCULOSIS

Mr. BUSBEY. About a year ago the newspapers and the magazines publicized a new discovery that was purported to be a cure for tuberculosis. I do not recall that you touched on that in your general statement. Would you like to tell us about it briefly?

Dr. SCHEELE. Yes. This is a vitaminlike drug. The general name for the drugs is isoniazid drugs. It was hoped these drugs might have almost 100 percent curative effect on tuberculosis, and some of the earlier cases showed rather dramatic improvement. Their temperatures went down to normal and, almost literally, in a few days the volume of their sputum decreased tremendously. In many of them it became impossible to readily find the tubercule bacilli which had formerly been present in the smears of their sputum. In these cases, and in the cases of all drugs we use in treating diseases, we always worry about the problem of so-called drug resistance. We worry about strains of tubercule bacilli in this case that survive the impact of the drug and let the disease go on. In the case of these drugs, it was found through scientific research that a certain amount of

drug resistance did develop in the tubercule bacilli and that one could, on careful study, still find some live bacilli in many of the patients.

The research that has been done would seem to indicate that these drugs, by themselves, are useful adjuncts in the treatment of TB, but are not in themselves cures, although only history and more time will tell whether we might put some patients in the category of having been cured by them alone. However, some very hopeful things have been happening.

We had at an earlier time, supported by this committee and the Congress, been provided funds for the Public Health Service to do studies on streptomycin, a drug that you have heard about. It was found that this drug, while not a cure for TB, was a very marvelous drug in controlling many forms of TB, and in helping the patient arrive at a point where he could in many cases be cured. So immediately the scientists began using not only the isoniazid drugs but began using, simultaneously or in a variety of ways, the isoniazid drugs with streptomycin. The streptomycin was enhanced by the addition of another drug, para amino salicylic acid, known by the initials PAS. The two together gave an end result that was manyfold better than the streptomycin alone. So at the present time, very excellent results are being obtained from a combination of three drugs, namely, streptomycin, PAS, and isoniazid. We have not heard the end of this story yet because there will be variants of the isoniazid drugs coming along one of these days. It would appear that they represent a step, a tremendous step, forward in the care of tuberculosis.

On the other hand, I would say these words of caution—these drugs, as far as we know at the moment, do not cure tuberculosis. We are not prepared to give these drugs unless we know the patient has tuberculosis, so we will still have to find the cases.

Some people have thought that we might be able to stop case finding, or that we might even be able to close hospitals because we now have these wonderful drugs, but when one stops to think about it, one will remember that we have to find the cases first. It has been found that these drugs alone are not enough, so we still have to use some of the techniques which have required, in many cases, hospitalization. Also, certain forms of lung collapse and certain nerve-cutting operations, cutting the phrenic nerve, to make the diaphragm inactive.

Occasionally there is active surgery on the chest. All these other procedures that we used in the past before we had the drugs are still important. It is a combination of all of them that is going to give us our improved results in tuberculosis.

The Public Health Service has been serving in this situation as it did in the streptomycin case. Our Chronic Diseases and TB Control Division set up a group of, I believe, 22 collaborating groups, or institutions, and arranged for each of these outstanding TB treatment centers to use common forms and to take X-rays at stated intervals and to pool all their information to the end that we would get the earliest possible scientific evidence of the real value of these drugs so that we would have more than, say, just the initial enthusiasm that came when the first announcement was made, and so that we would have a real objective scientific opinion of their true value, their limitations as well as their health effects.

FEDERAL EXPENDITURES FOR MEDICAL RESEARCH

Mr. BUSBY. Dr. Scheele, would it be possible for you to compile data showing the total amount of Federal funds that currently is being spent on medical research? By that I mean the funds being spent by all the agencies, such as the Atomic Energy Commission, the Veterans' Administration, the various military establishments, and any other agency of Government that might be allocating funds for medical research?

Dr. SCHEELE. The Bureau of the Budget might be a better source. On the other hand, we can get information on the Science Foundation. They are not supporting medical research directly; they are supporting some basic research which might have an end result in the health field. We can get some partial figures from the Atomic Energy Commission. We can get figures from the Veterans' Administration, but for the remainder of the atomic-energy program and the military program, I believe some of their research is classified and I do not believe they would furnish the figures to us on that. You would have to make a direct request for that information.

Mr. BUSBY. I have a lot of confidence in Mr. Harlow; I do not think it would be very difficult for him to secure that information.

Mr. HARLOW. Mr. Chairman, do not put too much faith in me. I can be overworked like anyone else. We will try, Mr. Chairman.

Mr. BUSBEY. Without objection, that will go in the record at this point.

(The information requested is as follows:)

EXPENDITURES FOR MEDICAL RESEARCH

Last year, the Nation spent an estimated $180 million for medical research. This is almost 10 times what we devoted to such research a decade ago. Of this sum, Government provided an estimated 42 percent, industry 33 percent, private philanthropy 14 percent, and hospitals and medical schools 11 percent.

(The above was taken from the President's message transmitting vol. I of the report of the President's Commission on the Health Needs of the Nation (H. Doc. No. 55, 83d Cong., 1st sess.).)

EFFECTIVENESS OF NEW TUBERCULOSIS DRUGS

Mr. FERNANDEZ. Dr. Scheele, in discussing tuberculosis, you said that you still have to find the cases. I do not quite understand what you mean.

Dr. SCHEELE. Many people thought that with the announcement of these new drugs, the isoniazid compounds, we could then relax our programs of case finding, but actually, unless one finds a case and finds out that a given individual has tuberculosis, which means that you still have to do the X-ray and the physical examination and the sputum examination, you do not know whether to give him the drug or not. It is not sound medical practice to have every person take the drug on the off chance that he might be one with tuberculosis.

Mr. FERNANDEZ. Does that mean that the drug has to be given before tuberculosis has developed?

Dr. SCHEELE. No, sir. I just meant that some of the enthusiasts earlier said, "Now we can stop the Public Health Service's case-finding program." We help the States find the tuberculosis cases by these mass chest X-rays. There has been one under way here with the cooperation of the District of Columbia for Members of Congress and for the people working for the Congress.

Many people thought that we could discontinue case-findng activity because the drugs had arrived. Unless we find the cases we do not know to whom to give the drugs.

STAFFING OF CLINICAL CENTER

Mr. FERNANDEZ. I understand now. If the budget recommendations had stood as they were first made to the Congress early in January, would you be able to go ahead with your staffing program for the Clinical Center as originally contemplated?

Dr. SCHEELE. Basically; yes. There might be some adjustments, but they would be relatively small.

Mr. FERNANDEZ. You would still be able to do so if at an early date the new Director of the Budget backs those recommendations and they are approved by the Congress?

Dr. SCHEELE. Well, at the moment he has the 1954 proposal under consideration. We do not yet have a final determination by him on what he is going to recommend to the President.

Mr. FERNANDEZ. You know nothing about what that is going to be, so far as the Clinical Center is concerned?

Dr. SCHEELE. No; not at the present time.

Mr. BUSBEY. Dr. Scheele, tomorrow morning we are going to start hearings on about 20 divisions of the Public Health Service. We not only hope that you will be able to sit in on many of them, but we also want you to know that you are always welcome before this committee.

Dr. SCHEELE. Thank you, Mr. Chairman.

WEDNESDAY, MARCH 25, 1953.

CONTROL OF VENEREAL DISEASES

WITNESSES

DR. JAMES K. SHAFER, CHIEF, DIVISION OF VENEREAL DISEASE
DR. OTIS L. ANDERSON, CHIEF, BUREAU OF STATE SERVICES
MISS HANNAH HOFF, ACTING BUDGET OFFICER, BUREAU OF STATE SERVICES

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$11,799,660	$9,850,000	$8,325,000
Transferred to—			
"Assistance to States, general, Public Health Service," pursuant to Public Law 452		−50,000	
"Salaries and expenses, defense production activities, Federal Security Agency," pursuant to Public Law 253	−121,000		
Adjusted appropriation or estimate	11,678,660	9,800,000	8,325,000
Reimbursements from non-Federal sources	6,859		
Total available for obligation	11,685,519	9,800,000	8,325,000
Unobligated balance, estimated savings	−144,719		
Obligations incurred	11,540,800	9,800,000	8,325,000
Comparative transfer to—			
"Assistance to States, general, Public Health Service"	−103,000		
"Salaries and expenses, Public Health Service"	−75,000	−75,000	
"Salaries and expenses, Office of the Administrator, Federal Security Agency"	−22,000	−34,825	
Total obligations	11,340,800	9,690,175	8,325,000

NOTE.—Reimbursements from non-Federal sources above are from the proceeds of sale of personal property (40 U. S. C. 481 (c)).

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
1. Grants to States for general venereal-disease control, case finding, and treatment	$9,331,390	$8,037,175	$6,695,000
2. Direct operations:			
(a) Clinical and laboratory research	370,638	365,000	365,000
(b) Technical assistance to States	1,390,081	1,043,000	1,020,000
(c) Administration	248,691	245,000	245,000
Total obligations	11,340,800	9,690,175	8,325,000

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Total number of permanent positions	735	661	546
Full-time equivalent of all other positions	16	12	11
Average number of all employees	635	551	500
Average salaries and grades:			
General schedule grades:			
Average salary	$4,629	$4,782	$4,920
Average grade	GS-7.2	GS-7.3	GS-7.6
Crafts, protective, and custodial grades:			
Average salary	$3,048	$3,051	$2,783
Average grade	CPC-3.9	CPC-3.9	CPC-3.0
Ungraded positions: Average salary	$3,162	$3,247	$3,247
01 Personal services:			
Permanent positions	$2,794,197	$2,539,200	$2,323,800
Part-time and temporary positions	58,525	40,600	37,600
Regular pay in excess of 52-week base	9,936	8,200	7,600
Payment above basic rates	16,014	12,000	8,000
Total personal services	2,878,672	2,600,000	2,377,000
02 Travel	223,926	175,900	171,400
03 Transportation of things	41,096	32,600	32,300
04 Communication services	18,798	15,500	14,500
05 Rents and utility services	18,337	8,800	3,800
06 Printing and reproduction	34,943	27,000	27,000
07 Other contractual services	99,584	67,500	65,500
08 Supplies and materials	428,229	255,000	235,000
09 Equipment	50,854	40,400	39,400
11 Grants, subsidies, and contributions	7,535,629	6,456,175	5,345,000
13 Refunds, awards, and indemnities	74		
15 Taxes and assessments	13,787	14,300	14,100
Subtotal	11,343,929	9,693,175	8,325,000
Deduct charges for quarters and subsistence	3,129	3,000	
Total obligations	11,340,800	9,690,175	8,325,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$522,430	$543,376	$548,376
Obligations incurred during the year	11,540,800	9,800,000	8,325,000
	12,063,230	10,343,376	8,873,376
Deduct:			
Reimbursable obligations	6,859		
Adjustment in obligations of prior years	132,355		
Unliquidated obligations, end of year	543,376	548,376	498,376
Obligated balance carried to certified claims account	3,081		
Total expenditures	11,377,559	9,795,000	8,375,000
Expenditures are distributed as follows:			
Out of current authorizations	10,990,565	9,410,000	7,990,000
Out of prior authorizations	386,994	385,000	385,000

Mr. BUSBEY. The committee will come to order.

We have before us for consideration this morning the appropriation request for fiscal year 1954 for "Control of venereal diseases, Public Health Service." Dr. Shafer, I believe you have a general statement you wish to make at this time.

Dr. SHAFER. Yes, I have, Mr. Chairman.

Mr. BUSBEY. All right, sir, you may proceed.

GENERAL STATEMENT

Dr. SHAFER. Mr. Chairman and members of the committee, as we discuss the current problems in venereal disease control, I should like to present a brief resume of the development of this program.

DEVELOPMENT OF VENEREAL DISEASE CONTROL PROGRAM

The increase in venereal disease rates, during and immediately after World War I, aroused the concern of the American public into official recognition of this dangerous public health problem. In 1918, grants were first made to States for the control of venereal disease. This initial grants program was allowed to die and venereal disease to spread relatively uncontrolled in the population during the twenties and early thirties.

By 1936, enough data had been accumulated to permit our Surgeon General to present to the public the serious magnitude of the venereal disease problem. This presentation helped to break down the inhibitions which had previously prevented open discussion of the venereal diseases. Congress responded by again appropriating funds for a national venereal disease control program.

World War II found State and local health departments working closely with the Public Health Service, the military, the Veterans' Administration, and voluntary health associations in a joint venereal disease control operation. In the course of the war, the Public Health Service demonstrated the effectiveness of penicillin in the treatment of syphilis and gonorrhea, helped establish a network of rapid treatment centers for venereal disease, and developed an efficient system of finding hidden infections.

As a result, it was possible to hold the line on syphilis incidence during the war period and to handle with dispatch the inevitable postwar upsurge in civilian incidence following the demobilization of 11 million service personnel. Since 1947, an intensive case-finding program has forced a continuous decline in syphilis.

It is an outstanding accomplishment of our time that venereal disease rates have declined consistently during our present period of mobilization. This phenomenon, unique in medical history, develops from the fact that when the mobilization period began, the armed services, the State and local health departments, and the United States Public Health Service were prepared for it. We had case finding and prevention techniques which had proven their effectiveness. We had reliable diagnostic procedures and effective treatment schedules. Most important, our efforts were united in an efficient working relationship backed with joint operational experience.

In order to insure that all infected persons in critical defense areas are interviewed for sex contacts, there are 150 venereal disease interviewers and investigators assigned, by State and local health depart-

ments, to military establishments, to defense impacted areas, and to recreational areas frequented by military personnel and defense workers. These men are specially trained in venereal disease interviewing and investigative methods.

1954 CONTROL PROGRAM

The venereal-disease-control program for fiscal year 1954 is directed toward finding and bringing to diagnosis 160,000 cases of untreated syphilis and 225,000 cases of gonorrhea. Operational activities will continue to be concentrated in defense and high prevalence areas, particularly in and around large cities, so as to prevent the spread of infection where additional control problems are imposed by the national-defense program. Special attention will be given to speeding up gonorrhea case finding in order to bring gonorrhea into a favorable measure of control. Grant funds to the States support laboratories providing tests for syphilis and diagnostic work for gonorrhea which are an integral part of this case-finding operation.

The reduction of $1½ million from last year's budget is an economy resulting largely from the development of an outpatient prevention and control center operation designed to provide services comparable with those formerly rendered by the network of rapid treatment centers.

A small percentage of the budget will continue to be expended for research and field studies aimed at maintaining standardized diagnostic tests, for developing methods for detecting and preventing the onset of cardiovascular and central nervous system syphilis, as well as other complications of veneral disease which do not readily respond to present treatment; and to providing consultation to State and local health department laboratories.

CURRENT PROBLEMS

Despite recent gains, venereal diseases still remain a serious public health problem. Lacking an immunizing agent, or the ability to locate and isolate all infected persons, our controls depend entirely on finding and treating cases before they transmit their disease. Furthermore, a major problem still exists in the huge reservoir of some 2,100,000 persons in the country today who are estimated to have undiscovered or inadequately treated syphilis.

Among the economic reasons for concern with this reservoir are: The loss of productive life among those disabled because of untreated syphilis, and the financial burden of their institutional care. Although there are convincing data on both of these types of economic loss, I shall present only one item. The direct cost to the taxpayer for the care of patients in mental institutions as a result of untreated syphilis is $790 per patient per year. Their average stay in a mental institution is 10 years. We may expect 52,500 such patients to be institutionalized if the reservoir maintains its present volume and character. Over the period of their hospitalization they would cost the American taxpayer over $414,000,000.

Our obligation to the public demands a reduction in this reservoir and full protection of our human resources by forcing still lower the incidence of venereal infection and by finding and treating the undiscovered condidates for disability and premature ɑeath.

STATE SUPPORT OF PROGRAM

Mr. BUSBEY. Dr. Shafer, on page 3 of your prepared statement, the last sentence of the first paragraph is as follows:

> Grant funds to the States support laboratories providing tests for syphilis and diagnostic work for gonorrhea which are an integral part of this case-finding operation.

Are not the States able to bear the cost of this program?

Dr. SHAFER. The States are supporting the venereal-disease-control program to a greater extent than the Federal participation in the program, and they are partially supporting the basic venereal-disease-control structure which includes the State laboratories which do serological testing and diagnostic work for gonorrhea. However, they, at the present time have not been able to completely support laboratories with their State and local funds.

Mr. BUSBEY. Why not?

Dr. SHAFER. The control program in the various States across the country has called for the basic services, which include not only the serological testing for syphilis, but the maintenance of administrative structure at the State and local level plus case-finding activities, and through the years as we have developed close teamwork in the venereal-disease-control program, there has been joint support of all of those activities from the State, local, and Federal resources.

Mr. BUSBEY. I appreciate that, and I think that is the way it should have been from the beginning. I cannot understand why at this stage of the program the States should not support the program entirely, except for the cooperative and consultative work of the Public Health Service.

Mr. HARLOW. Mr. Chairman, may I make one comment?

Mr. BUSBEY. Mr. Harlow, it is always a pleasure to have a comment from you.

Mr. HARLOW. I think your question is basic for the whole grants program, but there is an element here that applies more or less to all of our grant programs, but more specifically, I think, to the venereal-disease program, perhaps, than to some of the others. That is, that the bulk of the Federal funds is going into the States with the lowest per capita income, those, shall we say, least able to support their health activities entirely.

Furthermore, the situation with respect to the meeting of State legislatures in order to appropriate additional funds which would be necessary if Federal funds were reduced is in such a shape that certainly for 1954 we would not see this slack taken up.

I think only perhaps two of the legislatures have already met. Some of them will meet very soon. I think most of them will have their sessions over before there is any knowledge of what the Federal participation is going to be.

Mr. BUSBEY. I grant that that is true. It is the general argument that is brought forth every time the question of the termination of any of the grant programs is mentioned. It is not only brought up in regard to grant programs, but also, in regard to all subsidy programs, such as the parity programs and the soil-conservation program, and any other program where the Government is making grants to the various States, to organizations or to individuals.

I have mentioned in all the hearings my feeling that many of these grant programs must be terminated and eliminated altogether and that the States have got to assume their responsibility.

I notice in your charts on pages 4 and 5 of the justification that every State receives an allotment of these funds. Now certainly a great many of those States are financially able to take care of their own venereal-disease program without any help from the Federal Government.

In the case of low-income States, I am sympathetic to their problem and situation, but I do not think a grant program such as this should encompass every State.

REVIEW OF ALLOTMENT FORMULA

Mr. HARLOW. If we were to agree with that, Mr. Chairman, we would have to say, however, that according to the law we now operate under, every State must get an allotment under the formula. In this particular appropriation we do have authority to make what we call project grants, which are not under a formula basis, and a larger proportion of this money is going on a project basis.

Mr. BUSBEY. How long has that law been in effect?

Dr. DEARING. Since 1938.

Mr. BUSBEY. Has any recommendation been sent to Congress by the Public Health Service in regard to any change in the formula provided in the law?

Mr. HARLOW. We have some suggestions in the mill, Mr. Chairman; they have not yet reached the Congress.

Mr. BUSBEY. What has transpired in the past along those lines?

Dr. DEARING. Mr. Chairman, in the past Congress we had recommended authority for project grants, which at present is carried in appropriation language. That was started during the war when the formula was not flexible enough to put the money where it was needed most because of our military needs, but that change of basic law has never been enacted. It has been considered and, I believe, reported favorably, but it has never come to the floor. So the authority for the flexibility which the project method of making grants gives us is still carried in appropriation language.

Is that correct?

Mr. HARLOW: Yes.

Mr. BUSBEY. What has been done since this law has been in effect to review the formula, with a view toward reducing the Federal responsibility to the States under the formula?

Mr. HARLOW. The regulations giving the weight which we place to the three elements which enter into the formula—State need, extent of the problem, and population—are reviewed every year at the conference with the Surgeon General with the State and Territorial health officers. Those just govern the distribution of the money that Congress appropriates.

Mr. BUSBEY. Of course, you are not going to expect the States to initiate or promote any program that is going to reduce their grants. What is the formula that this money is distributed under, Mr. Harlow?

Mr. HARLOW. Do you have the formula?

PRESENT FORMULA

Dr. SHAFER. Yes, I have that, Mr. Chairman. The formula includes 23.6 percent devoted to population and financial needs; 26.6, to prevalence; 21.2 to early syphilis cases reported; 8.9 percent to the total of all syphilis, minus, of course, early syphilis; 13.3 percent to what we call equalizing services; and 6.4 percent to the number of blood tests that are carried out in State laboratories.

FEDERAL RESPONSIBILITY IN FEDERALLY IMPACTED AREAS

I would like to add a comment to the previous question on grants. The Federal responsibility is more acute now than in the postwar period because the bulk of our project grants are directed to those areas where the national interests have created an increase in the venereal-disease problem. I am speaking of the military installations where we have worked with the State and local health departments to assign men to keep the rates down in those military populations, the defense areas that have been hit especially hard with the dislocation of population, and the recreational areas that are frequented both by military and defense populations. The increase in the problem there is due to the national-defense effort, and we have worked with the State and local health departments to meet the problem in those areas.

Mr. BUSBEY. I notice that the State of Georgia, for instance gets almost twice as much of these funds as the State of Illinois. Why would that be? Its population is certainly less than half that of the State of Illinois.

Dr. SHAFER. The State of Georgia not only has a much greater venereal-disease problem but has been operating, during fiscal 1952 and the early part of the current fiscal year, a rapid-treatment center which would account for a large portion of these funds. However, that rapid-treatment center was closed down October 1, 1952, and the program in Georgia will be conducted through prevention and control centers in the large cities.

Mr. BUSBEY. The so-called prevention and control centers in effect are taking the place of the rapid-treatment centers; is that it?

Dr. SHAFER. That is correct, Mr. Chairman.

REPLACEMENT OF RAPID-TREATMENT CENTERS BY PREVENTION AND CONTROL CENTERS

Mr. BUSBEY. Explain these prevention and control center operations for the benefit of the committee.

Dr. SHAFER. The prevention and control centers, as you mentioned, are the replacement of the old rapid-treatment centers or the hospitals in which we treated venereal diseases. As our methods of treating syphilis have improved, we have been able to treat cases on an outpatient basis; that is, they do not need to be hospitalized. Because of this we are moving into prevention and control centers, which are essentially outpatient facilities.

However, we attempt to provide the same services in these outpatient centers as in the hospitals. By that I mean we would not only hope to have expert diagnostic and treatment services, but most important of all, we want epidemiology carried out in these clinics.

In other words, the cases must be interviewed for their contacts, and then, personnel must be available to search out these contacts and bring them in for diagnosis and treatment.

Actually, the way it works, there would be from 1 to 3 or 4 prevention and control centers in the States with a large venereal disease control problem. The prevention and control center usually is located in a large city, and we have completed arrangements with the State and local health authorities so that the patients may come into the centers from outside their jurisdictional area. In other words, a radius from 75 to 100 miles beyond the limits of this city.

In that way, we are able to extend diagnostic and treatment services to essentially the same areas that were covered by our rapid-treatment centers, and the economies that result are savings in the usual operating costs of a hospital—the nonprofessional personnel, cooks, attendants, food, et cetera.

OPERATING COSTS

Mr. BUSBEY. What is the cost of operating these prevention and control centers?

Dr. SHAFER. The cost varies considerably, Mr. Chairman. As I mentioned earlier, they are established in larger cities in conjunction with the local health-department clinics. We hope to provide good medical care, nursing care, and epidemiological service. So, essentially, the cost in each center is the cost that is required to add personnel and services to the already existing facility so as to give adequate, well-rounded venereal disease control service.

Mr. BUSBY. What would be a rough estimate of the overall cost?

Dr. SHAFER. In our first year's experience we have established some 35 prevention and control centers at a cost of about $650,000. So it averages out to less than $20,000 per center which, of course, is much less than it would cost to operate a hospital.

Mr. BUSBY. There is nothing in the law under which this program operates that says the Congress is obligated to appropriate a definite minimum amount, is there?

Dr. SHAFER. Not to my knowledge, sir.

COMPARISON OF FEDERAL AND STATE-LOCAL APPROPRIATIONS

Mr. BUSBEY. It still seems to me that States ought to have enough pride to take more interest in supporting this program themselves instead of looking to the Federal Government.

Dr. SHAFER. I might say, Mr. Chairman, that the history of State and local appropriations shows that they have started from a minimum of approximately 3 or 4 million dollars back in 1938, and they have come along almost dollar for dollar with the Federal appropriations until the year 1950, when the State and local appropriations surpassed the Federal appropriation for this program. I am speaking in 1949 of an appropriation of some $17 million Federal, with $16 million State and local. At the present time our current year's appropriation is $9,850,000, and yet the State and local appropriations have held up to $14,930,000, which indicates that the State and local health departments are assuming an ever greater proportion of the financing of this program.

Mr. BUSBEY. I think they are to be commended for that, but I still contend that they should be moving faster toward assuming the entire financial responsibility of the program.

RESERVOIR OF INADEQUATELY TREATED SYPHILIS CASES

Now at the top of page 4 you mentioned the fact that there is a huge reservoir of some 2,100,000 persons in the country today who are estimated to have undiscovered and inadequately treated syphilis. How was that figure arrived at? What is its significance?

Dr. SHAFER. This figure is derived from a baseline that was established during the selective-service figures from the Second World War. That was the only time in history that a good cross section of the population in this country has been blood tested to give us a fairly accurate indication as to how much syphilis we might expect to find in our population.

Using that as the baseline, we have estimated the number of new cases which would occur in any year. We have, of course, subtracted the cases that were discovered and treated. And I might say that in the past 10 years this reservoir has decreased some 1 million persons. The reservoir in 1941 was slightly over 3 million persons.

Mr. BUSBEY. Of course, that is just an estimate based upon what facts you can gather together.

Dr. SHAFER. That is true, Mr. Chairman.

Mr. BUSBEY. The last sentence in the next paragraph on page 4 states:

> Over the period of their hospitalization they would cost the American taxpayer over $414 million.

That refers back to the cost of caring for mental cases resulting from untreated syphilis.

Now for the most part these mental institutions are operated by the States; therefore the savings would accrue to the States. So why should they not bear the expense of this program?

Dr. SHAFER. As I indicated, the States are assuming an ever greater share of this burden, and yet we feel that the most pressing venereal-disease problems in the United States today have been created by our national-defense effort. Therefore, we feel that we should stand shoulder to shoulder with the State and local health departments in trying to wipe out this reservoir of 2,100,000 persons.

Mr. BUSBEY. A couple of years ago, when this appropriation item was under consideration by the committee, I gained the impression that the number of cases would be decreasing more rapidly than your chart on page 4 of the 1954 justifications indicates it has.

Is there any particular reason why greater progress has not been made in reducing the number of cases?

Dr. SHAFER. I think that problem rests squarely with the fact that our present mobilization has created new venereal-disease problems that we did not anticipate 2 and 3 years ago. Our appropriation has gone down rather sharply, largely because of our ability to close rapid-treatment centers. At the same time, we have been forced to cut off case-finding personnel, and the fewer case-finding personnel we have, the longer it will take to wipe out our reservoir of untreated syphilis.

FUNDS REQUESTED OF BUDGET BUREAU

Mr. BUSBEY. How much did this Division request originally of the Bureau of the Budget for fiscal year 1954?

Dr. SHAFER. It was $8,653,000.

Mr. BUSBEY. And they allowed $8,325,000?

Dr. SHAFER. That is correct.

Mr. BUSBEY. That is the original, so-called Truman budget figure, is it not?

Dr. SHAFER. That is correct.

Mr. BUSBEY. Do you expect soon to have a revised budget figure?

Dr. SHAFER. I have no information on that, sir.

Mr. HARLOW. Mr. Chairman, that is being reviewed right now. That is one reason why the Surgeon General is not here this morning; he is right in the midst of a hassel on that particular thing right now.

TRANSFERS TO OTHER APPROPRIATIONS

Mr. BUSBEY. This request is a decrease of $1,525,000 from the 1953 appropriation. However, functions estimated to cost $159,825 are being transferred to other appropriations. So the decrease in the request is actually $1,365,175. What is the reason for those transfers?

Mr. HARLOW. Mr. Chairman, the Congress, as you recall, last year authorized us to transfer funds between appropriations for the pay of commissioned officers; $50,000 of that transfer was made to the appropriation "Assistance to States, general," on that account; $75,000 of the transfer is to appropriation "Salaries and expenses, Public Health Service," involving the consolidation of several publications into one publication which we had heretofore called Public Health Reports, and for tabulating services which were at one time handled by the Division of Venereal Diseases but are now handled in the Office of Vital Statistics, where they have a very large tabulating operation. And this represents this part of the tabulating service that will be rendered by the Office of Vital Statistics.

Then ever since the Federal Security Agency library was set up to cover the whole agency and its constituents, we have been paying the salaries of some of the library workers. It was thought at this time it was appropriate to transfer those salaries to the Office of the Administrator. In addition, there are, I think, two personnel positions which were involved in this transfer in the Office of Personnel of the agency. That latter item accounts for $34,825.

Mr. BUSBEY. Does "vital statistics" come under "Salaries and expenses for Public Health Service"?

Mr. HARLOW. No, sir, they come under another appropriation. But this thing has a historical base.

Many, many years ago now, I guess at least 15 or 20 years ago, when the tabulating machines were first established in the Division of Venereal Diseases, it was decided that they at the same time would be able to do all of the tabulating work that was necessary for the Office of the Surgeon General, and the money was carried in that appropriation all through the years. It more properly belongs in the appropriation which carries the salaries and expenses of the Surgeon General's Office. That is why we are transferring it here.

LEVEL OF APPROPRIATIONS SINCE INAUGURATION OF PROGRAM

Dr. ANDERSON. May I make a comment on the extent of the appropriation and reductions?

Mr. BUSBEY. Yes.

Dr. ANDERSON. I note here that the first appropriation made under the Venereal Disease Control Act in 1939 was $3,080,000, and subsequent years' appropriations have gradually increased to 1949, when a total of $17,399,500 was appropriated. Then each subsequent year since then there has been a rather rapid reduction in terms of dollars to support programs to the present-year estimate of $8,325,000, a reduction of about 50 percent from the high point in 1949.

From the program point of view and the technical point of view of the program, we feel the venereal disease control program has accomplished a very remarkable record and, in fact, as it is continuing, will literally work itself out of business. In other words, it is a very worthwhile and satisfactory sign of accomplishment to have reduced this large reservoir of infection to the present level and in a period of 14 years—accomplish what we have to date. So we believe the reduction in funds has been very rapid in relation to the extent of the program.

Mr. BUSBEY. I think that the results of the program have been excellent. I am not quarreling with the results.

What did you say the appropriation was in 1939?

Dr. ANDERSON. In 1939 it was $3,080,000. That was the first appropriation made under the new Venereal Disease Control Act passed, I believe, in 1938.

PERCENTAGE RELATIONSHIP OF FEDERAL GRANTS TO TOTAL STATE FUNDS

You were talking a moment ago about the percentage of Federal funds that constitute a part of the total public-health expenditures in the States. It might be interesting to note that in a study we made for the year 1951, the percentage of Federal participation in total public-health expenditures in the States amounted on the average to 21.7 percent for all States, and that will vary up and down between the various States and Territories. For example, in Alaska, the percentage of Federal fund participation is 78.9 percent, and in the State of New York the percent of Federal participation is 8 percent.

So your formula on population, extent of financial need, and the extent of the problem are influencing factors which bring to bear Federal funds in those particular areas where your problem is large and where your financial need is great.

VENEREAL DISEASE CASES AND DISTRIBUTION OF FEDERAL GRANTS TO STATES

Mr. BUSBEY. Without objection, we will put the tables on pages 4 and 5 of the justification in the record at this point.

(The tables are as follows:)

Venereal disease morbidity—Total cases reported for United States civilian population (including Territories), 1941–52

Fiscal year	Total cases of venereal diseases	Syphilis	Gonorrhea	Other venereal diseases
1941	688,334	487,720	195,194	5,420
1942	710,687	483,319	218,473	8,895
1943	879,988	586,771	280,332	12,885
1944	802,395	482,167	307,504	12,724
1945	677,072	370,949	295,881	10,242
1946	761,655	373,631	375,761	12,263
1947	906,380	382,095	509,776	14,509
1948	731,855	345,992	372,167	13,696
1949	651,577	296,551	342,863	12,163
1950	561,722	238,640	313,517	9,565
1951	494,790	208,137	278,898	7,755
1952 [1]	436,221	175,936	254,159	6,126

[1] Provisional.

Distribution of grant-in-aid funds for venereal-disease control

State or Territory	1952 obligations	1953 allocations
Alabama	$307,129	$382,200
Arizona	70,498	82,642
Arkansas	557,912	296,484
California	161,299	171,723
Colorado	39,058	46,300
Connecticut	33,854	35,705
Delaware	17,614	17,800
District of Columbia	187,354	148,155
Florida	528,381	532,750
Georgia	961,144	552,432
Idaho	30,219	35,050
Illinois	294,890	296,318
Indiana	97,732	90,605
Iowa	52,766	57,170
Kansas	46,822	48,327
Kentucky	323,946	226,181
Louisiana	526,692	497,775
Maine	17,691	18,700
Maryland	169,772	150,600
Massachusetts	52,577	50,765
Michigan	142,273	165,769
Minnesota	26,106	25,900
Mississippi	568,135	362,739
Missouri	296,952	200,189
Montana	18,031	17,300
Nebraska	42,681	27,550
Nevada	19,153	21,840
New Hampshire	12,103	12,800
New Jersey	81,214	96,445
New Mexico	30,502	79,293
New York	235,490	268,335
North Carolina	497,456	345,973
North Dakota	26,363	25,055
Ohio	299,225	227,883
Oklahoma	153,522	135,296
Oregon	25,959	25,800
Pennsylvania	158,850	287,655
Rhode Island	16,041	15,500
South Carolina	495,925	263,112
South Dakota	18,696	17,600
Tennessee	180,254	183,038
Texas	700,538	635,612
Utah	19,402	20,775
Vermont	11,313	13,900
Virginia	155,920	179,489
Washington	37,294	39,892
West Virginia	167,648	147,208
Wisconsin	20,696	28,800
Wyoming	18,730	16,500
Alaska	26,749	36,892
Hawaii	16,794	16,200
Puerto Rico	313,814	350,053
Virgin Islands	14,469	12,100
Reimbursements from non-Federal sources	5,742	[2] 0
Total	9,331,390	[1] 8,037,175

[1] Includes allocations of $1,225,000 for in-patient treatment and $3,350,000 for case finding, out-patient treatment, and other control activities.

EFFECTIVENESS OF CASE-REPORTING PROGRAM

Mr. BUSBEY. Is it not true that the table showing the total cases of venereal disease considerably understates the drop in cases during this 12-year period, since a much higher percentage of the cases are now being reported than in past years? In other words, in these earlier years you did not have the same efficiency in case reporting that you developed in the later years, did you?

Dr. SHAFER. It is my impression, Mr. Chairman, that the increased efficiency in reporting took place in about 1938. As I recall the record of syphilis cases reported, there was a tremendous increase in number of cases found starting in 1938 and 1939; so that the statistics on page 4 show approximately the same efficiency in reporting as we have today. In fact, I would predict that fewer cases are being reported proportionately today simply because, with the ease of treatment and the short period of time required for treatment, many cases are diagnosed and treated, with failure to report the case. This is especially true in gonorrhea where many times the diagnosis is not established by laboratory procedures.

DEATHS FROM SYPHILIS

Mr. BUSBEY. What is the trend during this 12-year period, in the number of persons that have died from venereal disease?

Dr. SHAFER. The mortality rate from syphilis has been cut slightly over 50 percent in this 10-year period. The last mortality figures we have are for 1951, and we had some 7,000 deaths from syphilis.

Mr. BUSBEY. Would it be possible for you to furnish a table for the record on the number of deaths from syphilis during these years?

Dr. SHAFER. I would be most happy to supply it.

(The information is as follows:)

Deaths from syphilis, continental United States 1941–51

Year	Fifth Revision of International Lists of Causes of Death		Sixth Revision of International Lists of Causes of Deaths	
	Cases	Rate [1]	Cases	Rate [1]
1941	17,728	13.3		
1942	16,345	12.2		
1943	16,263	12.1		
1944	14,916	11.2		
1945	14,062	10.6		
1946	12,955	9.3		
1947	12,671	8.8		
1948	11,616	8.0		
1949			8,581	5.8
1950			7,568	5.0
1951			[2] 7,074	[2] 4.6

[1] Per 100,000 population.
[2] Based on 10 percent sample of death certificates.

NOTE.—As a result of the revision of the International Lists of Causes of Death (World Health Organization) in 1948, syphilis deaths were reduced an estimated 26 percent solely because of the change in the method of classifying deaths.

Source: National Office of Vital Statistics.

LOSS OF ECONOMIC PRODUCTIVITY DUE TO VENEREAL DISEASE

Mr. BUSBEY. How would the number of man-years of productivity lost as a result of venereal disease during 1952 compare with the number lost 10 years ago?

Dr. SHAFER. The loss of man-years would be approximately the same, once the cases were hospitalized for neurosyphilis or cardiovascular syphilis. The average income, of course, per man-year lost, would be considerably greater than in 1941.

Mr. BUSBEY. But it is much easier to treat these cases and prevent these diseases today than it was 10 years ago?

Dr. SHAFER. That is correct, Mr. Chairman. But once the syphilis has invaded the nervous system—and in many cases we are unable to locate the case until such damage has taken place—then the patient must enter an institution and be hospitalized there for some considerable length of time.

I might point out that in 1941 there were slightly under 10,000 cases entering hospitals every year because of psychoses due to syphilis and during the last reported year, which was 1951, there were only 3,750 cases. So the number of cases suffering from complications of syphilis, that is, neurosyphilis, have been drastically reduced in this 11-year period.

PASSENGER MOTOR VEHICLES

Mr. BUSBEY. I notice in the budget that this Division has 95 automobiles. Will you furnish a statement for the record showing where each automobile is located, what it is used for, and how many miles it was driven the first 6 months of fiscal year 1953?

Dr. SHAFER. That information could be provided, sir.

Mr. BUSBEY. Without objection, that will be inserted in the record at this point.

(The information will be found at p. 649.)

Mr. BUSBEY. Now, for the benefit of the committee, could you tell us why you need 95 automobiles?

Dr. SHAFER. These automobiles are used primarily by our field investigators who are located in and around military installations. When a military installation has a critical veneral-disease control problem, they first ask for help in epidemiology from their neighboring local health department, or, if there is no local health department, from the State health department. If the State and local health departments are able to meet that need, they do. In those cases where they are unable to supply a man to do this epidemiological work, the Public Health Service will then provide a man who will move into the military installation, interview these cases for their contacts in the civilian population, and then go out and find those contacts and bring them to diagnosis and treatment. For that type of work they need an automobile.

FIELD STAFF

Mr. BUSBEY. How many persons are in the field on this kind of work?

Dr. SHAFER. We have approximately 571 people in the Venereal Disease Division. However, we have only 50 of these investigators that are assigned directly to military installations.

You were referring specifically to the investigators assigned to military installations?

Mr. BUSBEY. No, all persons working in the field.

Dr. SHAFER. Of the 571 that we have working, as of today, there are slightly under 500 of those in the field.

Miss HOFF. There are 460 in the field.

Mr. BUSBEY. The 50 investigators you referred to are assigned to military installations?

Dr. SHAFER. Directly to military installations.

I might add, there are approximately 100 such investigators who are assigned to military installations by State or local health departments. They are not Federal personnel.

Mr. BUSBEY. I take it that no arrangement has been made whereby you are reimbursed by the Department of Defense for the activities of personnel assigned to military installations?

Dr. SHAFER. No, sir. Their work is also carried out with adjacent local health departments wherever possible. So in many cases their work is not completely of a military nature. However, their contacts are always in the civilian population.

EXPLANATION OF APPROPRIATION LANGUAGE

OPERATION AND MAINTENANCE OF RAPID-TREATMENT CENTERS

Mr. BUSBEY. The language of the bill that appears on page 116 of the committee print provides for the operation and maintenance of centers for the diagnosis, treatment, support, and clothing of persons afflicted with veneral disease.

Would you explain that provision? I am going to indicate the different items here one by one and ask for a little explanation of each of them.

Dr. SHAFER. Those particular phrases refer to our operation of rapid-treatment centers, which we have had since about 1943, and permit us to operate these hospitals where the cases are diagnosed, treated, the epidemiology done, and complete venereal-disease-control service given to those people.

Mr. BUSBEY. What did you say in regard to 1943?

Dr. SHAFER. That was approximately the time that our rapid-treatment-center operations were started in this country. In other words, hospital treatment of syphilis patients was not feasible until we found that penicillin was effective in the treatment of syphilis, and, as our treatment methods were improved and shortened, it became feasible to put these syphilis patients into hospitals, treat them in a period of from 5 to 10 days, and then discharge them with their treatment complete; the patient completely noninfectious; and a careful history taken as to their sex contacts so we could further reduce this reservoir of syphilis by finding these contacts.

TRANSPORTATION AND SUBSISTENCE OF PATIENTS AND THEIR ATTENDANTS

Mr. BUSBEY. The next item in the language is "Transportation and subsistence of such persons and their attendants to and from the place of treatment, or allowance in lieu thereof."

Dr. SHAFER. This simply provided for transporting the patient to the hospital. It was found it was cheaper to establish only 1 or 2 hospitals per State in the high prevalence areas than to have hospitals located in 6 or 8 areas of the State. Therefore, transportation of patients was provided so we could bring them to the central-treatment source.

Mr. BUSBEY. And you also pay the transportation costs for any attendants with the patient that might be necessary?

Dr. SHAFER. That is true. And I might say it is very rarely that an attendant is needed to bring these cases to treatment.

Mr. BUSBEY. How much do you show in your 1954 budget as estimated expenditures in 1953 and 1954 for this item?

Dr. SHAFER. The transportation of patients?

Mr. BUSBEY. Transportation and subsistence of patients and attendants.

Dr. SHAFER. I do not have that information immediately available sir, but I will be able to provide it for the record.

Mr. BUSBEY. If you will, please.

DIAGNOSIS AND TREATMENT THROUGH CONTRACTS WITH PHYSICIANS, HOSPITALS, ETC.

Mr. BUSBEY. What is the explanation of the next part of the appropriation language?

Diagnosis and treatment (including emergency treatment for other illness) of such persons through contracts with physicians and hospitals and other appropriate institutions

Dr. SHAFER. The syphilis patients may develop other acute medical emergencies while they are in our hospitals, and it is necessary occasionally to have surgery done or to perform obstetrical services on some of the female patients.

I might say that the hospitals which we operated were not hospitals in the usual sense. We were able to work with the State and local health departments in taking over abandoned NYA camps, CCC camps, inactivated military installations, and the hospitals were hospitals in the venereal-disease sense only. In other words, they provided only the minimum essential medical services for venereal-disease control. Naturally, when a medical emergency requiring surgery arose, it was necessary in most cases to move these patients to a neighboring institution where they could be properly handled.

Many females late in their pregnancy were discovered to have syphilis, and the treatment of these cases sometimes was complicated by the patient going into labor, and our hospitals for the most part were not equipped to give obstetrical services.

Mr. BUSBEY. Would you furnish for the record the estimated cost of this program for 1953 and 1954?

Dr. SHAFER. Yes, sir.

Mr. BUSBEY. In fact, I should appreciate it if you would furnish such information for each of these six items of the appropriation language we are discussing.

Dr. SHAFER. Certainly.

(The information is as follows:)

Cost of venereal-disease treatment facilities, with certain selected items indicated

	Fiscal year 1953	Fiscal year 1954
Operation and maintenance of in- and out-patient facilities	$2,271,388	$1,275,000
Including—		
(1) Patient transportation	70,523	53,000
(2) Diagnosis and treatment of venereal-disease patients through contracts	27,611	500
(3) Emergency treatment of patients for diseases other than venereal outside of venereal-disease treatment facilities	591	1,200
(4) Leasing of facilities	12,647	15,000
(5) Repairs and alterations to leased facilities	24,524	7,000

NOTE.—Expenditures for preparation of remains and burial of patients is not carried as a separate item since most centers do not incur such expense during any single year of operation.

FEES FOR CASE FINDING AND REFERRAL TO CENTERS OF VOLUNTARY PATIENTS

Mr. BUSBEY. The next one is "Fees for case finding and referral to such centers of voluntary patients."

Dr. SCHAFER. That would refer to programs that were established several years ago in 1 or 2 States, one of which was Illinois, in which the private physicians were paid a fee for diagnosing and referring to rapid-treatment centers any cases of syphilis. I might say that particular part of the program is not in operation at the present time.

Mr. BUSBEY. In other words, then, that language could be dropped from the bill?

Dr. SHAFER. It is my impression that it could.

REASONABLE EXPENSE OF PREPARING REMAINS FOR BURIAL

Mr. BUSBEY. The next item is "Reasonable expenses of preparing remains or burial of deceased patients."

Dr. SHAFER. Naturally, there have been a very few cases where patients were in such condition that they did not survive treatment, or expired because of conditions other than venereal diseases while they were in our hospitals.

Mr. BUSBEY. In those cases you supply the money for all the expenses of the burial of these patients?

Dr. SHAFER. That is true.

Mr. HARLOW. That should be qualified, Mr. Chairman. That depends upon the ability of the family to claim the body and to make the necessary preparations.

Dr. SHAFER. Yes.

Mr. BUSBEY. Thank you, Mr. Harlow.

RECREATIONAL SUPPLIES AND EQUIPMENT

What is covered by the next item in the appropriation language: "Recreational supplies and equipment"?

Dr. SHAFER. At the time that these hospitals were started, the period of treatment was approximately 10 days; and, since the period of actual treatment in each day took only a very few minutes it was necessary to keep these people occupied doing something, and a minimum of what might be called recreational equipment was provided, such as magazines and radios. In some of these institutions we found woodworking equipment when we took over the centers, and we were able to utilize such facilities for occupying the time of these patients while they were in the hospital.

Mr. BUSBEY. And the last appropriation item refers to "Leasing of facilities and repair and alteration of leased facilities."

Do you have to do very much of that?

Dr. SHAFER. That was held to a minimum simply because we were able to occupy Federal buildings that had been abandoned by other agencies in Government, such as NYA camps, CCC camps, and military installations; but in some areas it was necessary to occupy quarters for which we paid rent.

Mr. BUSBEY. Thank you very much, Dr. Shafer.

Dr. SHAFER. Thank you.

WEDNESDAY, MARCH 25, 1953.

CONTROL OF TUBERCULOSIS

WITNESSES

DR. ROBERT J. ANDERSON, CHIEF, DIVISION OF CHRONIC DISEASE AND TUBERCULOSIS
DR. OTIS L. ANDERSON, CHIEF, BUREAU OF STATE SERVICES
MISS HANNAH HOFF, ACTING BUDGET OFFICER, BUREAU OF STATE SERVICES

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$8,806,750	$8,240,000	$7,645,000
Transferred to "Salaries and expenses, defense production activities, Federal Security Agency," pursuant to Public Law 253	−20,000		
Adjusted appropriation or estimate	8,786,750	8,240,000	7,645,000
Reimbursements from non-Federal sources	321		
Total available for obligation	8,787,071	8,240,000	7,645,000
Unobligated balance, estimated savings	−23,005		
Obligations incurred	8,764,066	8,240,000	7,645,000
Comparative transfer to—			
"Assistance to States, general, Public Health Service"	−154,263		
"Salaries and expenses, Public Health Service"	−11,103	−18,000	
Total obligations	8,598,700	8,222,000	7,645,000

NOTE.—Reimbursements from non-Federal sources above are from the proceeds of sale of personal property (40 U. S. C. 481 (c)).

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
1. Grants to States for tuberculosis control activities	$5,799,514	$5,300,000	$5,300,000
2. Direct operations:			
(a) Cooperative applied research	735,494	915,400	915,000
(b) Technical assistance to States	1,834,010	1,787,480	1,211,000
(c) Administration	229,682	219,120	219,000
Total obligations	8,598,700	8,222,000	7,645,000

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Total number of permanent positions	461	421	370
Full-time equivalent of all other positions	11	13	14
Average number of all employees	391	392	340
Average salaries and grades:			
General schedule grades:			
Average salary	$4,128	$4,133	$4,218
Average grade	GS-5.7	GS-5.6	GS-5.7
Crafts, protective, and custodial grades:			
Average salary	$2,907	$2,858	$2,836
Average grade	CPC-3.3	CPC-3.4	CPC-3.2
Ungraded positions: Average salary	$2,848	$3,110	$3,119
01 Personal services:			
Permanent positions	$1,722,718	$1,748,525	$1,547,918
Part-time and temporary positions	38,928	56,006	56,006
Regular pay in excess of 52-week base	5,094	5,319	4,564
Payment above basic rates	10,044	5,078	5,078
Total personal services	1,776,784	1,814,928	1,613,566
02 Travel	363,040	373,950	227,215
03 Transportation of things	15,730	15,194	10,194
04 Communication services	9,879	11,950	11,950
05 Rents and utility services	18,098	17,780	17,780
06 Printing and reproduction	27,626	37,550	33,050
07 Other contractual services	347,292	389,647	243,647
08 Supplies and materials	153,447	215,525	161,765
09 Equipment	68,583	59,916	21,273
11 Grants, subsidies, and contributions	5,813,114	5,300,000	5,300,000
13 Refunds, awards, and indemnities	507		
15 Taxes and assessments	4,600	5,560	4,560
Total obligations	8,598,700	8,222,000	7,645,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$464,103	$346,820	$376,820
Obligations incurred during the year	8,764,066	8,240,000	7,645,000
	9,228,169	8,586,820	8,021,820
Deduct:			
Reimbursable obligations	321		
Adjustment in obligations of prior years	79,973		
Unliquidated obligations, end of year	346,820	376,820	371,820
Obligated balance carried to certified claims account	264		
Total expenditures	8,800,791	8,210,000	7,650,000
Expenditures are distributed as follows:			
Out of current authorizations	8,416,925	7,910,000	7,340,000
Out of prior authorizations	383,866	300,000	310,000

Mr. BUSBEY. The committee will come to order.

The next item we have before the committee for consideration is the appropriation request for fiscal year 1954 for "Control of tuberculosis, Public Health Service."

Dr. Anderson, I believe you have a statement you would like to present at this time.

Dr. ROBERT J. ANDERSON. I do, sir.

Mr. BUSBEY. You may proceed.

GENERAL STATEMENT

Dr. ROBERT J. ANDERSON. Mr. Chairman and members of the committee, I appreciate this annual opportunity to report to you on the national campaign against tuberculosis and the Public Health Service's part in that campaign.

Soon after I testified last year, the press carried front-page stories about a new anti-tuberculosis drug later named "isoniazid." It is easy to see why the press seized upon this news, with its hope for patients and families, as well as the important economic implications. Tuberculosis is a continuing drain upon our economy, in the $300 million spent annually by the States for hospitalization as well as the countless productive man-years lost each year. I will explain later, however, that isoniazid has not proved to be the wonder drug nor the miracle cure that we had all hoped for.

TRENDS IN INCIDENCE AND TREATMENT OF TUBERCULOSIS

The annual number of tuberculosis deaths has declined from 84,000 in 1930 to 30,000 in 1951, as shown by the dotted line in chart 1. The more rapid decline after 1946 occurred as State control programs were strengthened by our activities under this appropriation. On the other hand, the solid line, which shows the number of new tuberculosis patients diagnosed annually, does not show a corresponding decline. This number remains about 120,000 each year. This is not all of the cases of TB, since the undiscovered sufferers from tuberculosis are not shown in these statistics. Wherever we look for it, we find tuberculosis. In every 1,000 presumably well people who have chest X-rays, we still discover one active highly contagious case of tuberculosis—of all kinds of pulmonary tuberculosis we find 7 cases per thousand examined—and undiscovered cases of tuberculosis spread this communicable disease.

The number of patients admitted to tuberculosis hospitals has also increased over the past 20 years, from 80,000 in 1931 to 108,000 in 1951, as shown by the solid line in chart 2. However, this chart does not show the tens of thousands of tuberculosis patients who are awaiting admission to the hospital. These patients, in the meantime, receive the treatment and nursing services provided by the States with the help of our grants-in-aid, thus starting the precautions against the spread of the disease.

Chart 3 indicates the number of patients in tuberculosis hospitals at any given time, the average daily patient census. Note that there is very little difference between these figures and the admission figures shown on the previous chart. A hospital caring for illnesses of short duration would show, in a year, many more admissions than its number of patients at any one time. This comparison illustrates the stubborn nature of tuberculosis, which remains a long-term illness despite improvements in treatment methods. A stay of 3 years in a tuberculosis hospital is not uncommon, and many patients make more than one trip to the hospital. To encourage patients to take full advantage of treatment, we have worked for improvement of the quality of patient services.

These charts demonstrate that, although great strides have been made against tuberculosis as a killer, tuberculosis as a cause of long and crippling illness has been more obstinate. That is why the Public Health Service program under this appropriation aims at finding people with tuberculosis early, shortening the course of their illness and preventing its spread to others. When all our efforts to find new cases can locate but a few—and when all these new patients can be hospitalized—and when admissions to tuberculosis hospitals

show a continued decline—then we will at last be able to say that tuberculosis is finally on its way out. To hasten this day, we must have adequate tuberculosis control services and vigorous control programs in every State. Federal grants-in-aid have enabled the States to find more people with tuberculosis; to diagnose and treat them in clinics and doctors' offices; to give them care in their homes and protect others from the disease.

Our gains are shown on this first chart that I showed you. Our patient load is shown here. As we proceed with an undiminished and intensified tuberculosis-control program, we will push down further the death rate. Possibly we will increase the number of newly diagnosed cases, and then ultimately it too will dip, and as we decrease the gaps in our tuberculosis-control program, we are going to decrease the gap between these two lines.

DIRECT ASSISTANCE IN CONDUCTING MASS CHEST X-RAY CAMPAIGNS

One of the activities in our direct operations is the service we offer metropolitan areas wishing to conduct mass chest X-ray campaigns.

You might be interested to know that today we start in Pittsburgh a cooperative program with the Pittsburgh City Health Department, the Pittsburgh-Allegheny County Medical Society, and the Pittsburgh-Allegheny County Tuberculosis Association.

No city alone has sufficient equipment or enough trained people to do this job, nor would it be economical to attempt it unaided. Therefore, we provide X-ray machines, technicians to operate them, and a professional staff experienced in the planning and operation of mass chest X-ray surveys. This strikes at tuberculosis where it is most prevalent. The large cities contain 29 percent of our total population but account for 43 percent of the tuberculosis deaths.

By the end of fiscal year 1953, we will have helped 20 large cities and 5 other heavily populated areas X-ray nearly 8 million people. We will have found 56,000 cases of tuberculosis in various stages of the disease, almost 90 percent of these previously unknown. In addition, we will have referred 80,000 persons to physicians because of X-ray findings suspicious of heart disease, lung cancer or other diseases of the chest. In the current fiscal year, we will X-ray 1,400,000 people and find 1,400 highly contagious cases of tuberculosis alone. With the funds requested for this purpose in 1954, we will X-ray 700,000 people and discover 700 persons with contagious disease.

EFFECTIVENESS OF ISONIAZID DRUG IN TREATING PULMONARY TUBERCULOSIS

Our evaluation of isoniazid—that is, iso-nicotinic acid hydrazide—which is supported by the funds requested for research, is now proceeding in cooperation with 21 city and State tuberculosis hospitals, and the famous Trudeau Laboratory at Saranac Lake, New York. Begun soon after the new drug was first announced, this research project now includes over 2,000 patients, more than any individual hospital or physician could study. Thus far, isoniazid gives no promise of being more effective in the treatment of pulmonary tuberculosis than anything we now have. Although it does provide another weapon against the disease, it does not come up to the high hopes many once

held for it. Some of the patients who a year ago were pictured dancing in their wards have since died. Of course, those were people whose disease was far advanced when they began to take isoniazid. The chances for successful treatment are much better when tuberculosis is discovered in its early stages.

We can expect other and better—we hope—drugs to come along.

This is why the national campaign against tuberculosis must continue to emphasize early discovery through chest X-rays of apparently well people. To arrive at the best dosage and combination of drugs, the studies with these hospitals are continuing.

EVALUATION OF VACCINATION FOR TUBERCULOSIS

Our research program also includes the evaluation of vaccination for tuberculosis. Years must pass, of course, before the immunizing effects of any vaccine show themselves fully. It was in 1948 and '49 when we started the first large-scale controlled experiment with BCG in the island of Puerto Rico, and it took us 2 years to test and vaccinate all of the school children in that island. We are now watching that group to see how many cases of tuberculosis will develop in the various categories. Thus, we have set up the trials for BCG vaccine and are experimenting in the laboratory with other products. In Columbus, Ga., we are continuing our long-range epidemiological study of the development and amount of tuberculosis in a representative American community and of the effect of different tuberculosis control measures. Our small but vital radiological laboratory protects the health of X-ray workers and standardizes the X-ray equipment and supplies used by the Public Health Service and others.

The price of tuberculosis will be high for many years to come. Shall this cost be counted in lives lost prematurely, in years of sickness, in loss of working life and in a never-ending problem? Or shall we work to prevent untimely death, to shorten the years of disability and dependency, to limit the spread of tuberculosis and thus ultimately to control the disease? Each case represents a $30,000 drain on the resources of the country. The program, under this appropriation, needs to prevent only 250 cases of tuberculosis to pay its way as an investment in health.

STATE SUPPORT OF PROGRAM

Mr. BUSBEY. I hope Mr. Harlow will not get too tired of my dwelling on a pet subject of mine as the different divisions come before the committee.

On page 2 of your prepared statement, Dr. Anderson, in the last sentence of the first paragraph, you state:

> These patients, in the meantime, receive the treatment and nursing services provided by the States with the help of our grants-in-aid.

Is it your opinion that the Federal Government is in better financial condition to carry on this program than are the States?

Dr. ROBERT J. ANDERSON. I am not expert in that, sir. I cannot answer that.

Mr. BUSBEY. Why should not the States and communities bear all the costs of this program that individuals cannot bear?

Dr. ROBERT J. ANDERSON. The costs of the program for tuberculosis control in this country by the States and in the States themselves exceed $300 million for hospitalization, for example, in which none of this grant-in-aid money is used. The appropriations by State and local communities for activities of this general type are about $19 million on their part, matched by the $5,300,000 requested here.

In terms of the needs of the tuberculosis problem, as I indicated, the tuberculosis program, as we have it in this country today, is still not adequate in terms of meeting the total problem ahead of us.

The Federal Government, I think, has a very definite interest in tuberculosis control inasmuch as tuberculosis is a communicable disease and spreads from State to State. The Federal Government has its own program for cases of tuberculosis which costs between a quarter and a third of a billion dollars a year, sir, for Federal costs for cases of tuberculosis as they occur in Federal beneficiaries. I think that is reason for the Federal interest in good tuberculosis services over the country.

FEDERAL GRANTS COMPARED TO STATE AND LOCAL EXPENDITURES

Mr. BUSBEY. What percentage is the amount of funds the Federal Government grants to the States of the total amount spent, including all of the money spent by the States?

Dr. ROBERT J. ANDERSON. For the hospitalization and treatment?

Mr. BUSBEY. Yes.

Dr. ROBERT J. ANDERSON. And the Public Health Service?

Mr. BUSBEY. Yes.

Dr. ROBERT J. ANDERSON. I do not have that percentage calculated. I can do that and submit it.

Mr. BUSBEY. Just supply the amounts with the percentage, if you will please, for the record.

Dr. ROBERT J. ANDERSON. All right.

(The information is as follows:)

Tuberculosis—Federal grants-in-aid and funds reported by State and local health agencies, fiscal years 1950–53

Year	Total State, local, and Federal funds	Federal grants-in-aid	Grants as percentage of total funds
1953	$169, 196, 599	$5, 300, 000	3. 1
1952	149, 963, 573	5, 800, 000	3. 9
1951	143, 499 402	6, 350, 000	4. 4
1950	109, 443, 103	6, 790, 000	6. 2

DISTRIBUTION OF GRANT FUNDS

Mr. BUSBEY. What is the formula that is used in the distribution of these funds to the States?

Dr. ROBERT J. ANDERSON. A minimum grant of $8,000 is made to every State and Territorial health department in order to provide basic minimum central office services in the State health department

and to assure its operation. Then 20 percent of the money is distributed on the basis of population, weighted by per capita income and 35 percent of the money is distributed on the basis of the mortality, the proportion that each State has of the total national tuberculosis mortality. The balance is based upon the extent of activities and the desire of the States to conduct various types of programs.

Mr. BUSBEY. Do you not think that we ought to work toward the goal of letting the States take over the cost of this program except for the consulting and supervising services provided by the Public Health Service?

Dr. ROBERT J. ANDERSON. We have been working to improve the total content of tuberculosis service in the States and to make them more adequate in terms of the needs for tuberculosis control, and the States have come forward with increased contributions. Our contribution has shrunk.

Mr. BUSBEY. Is that formula you spoke of provided by law?

Dr. ROBERT J. ANDERSON. I do not think the formula is provided by law. It is provided by regulation.

Mr. HARLOW. The three basic elements of the formula are prescribed in the law. It is a matter of regulation as to the weight which shall be given to each.

Mr. BUSBEY. And who prescribes the regulation?

Dr. ROBERT J. ANDERSON. The Surgeon General does, sir, with the advice of the State and territorial health officers.

Mr. BUSBEY. Without objection, we will put in the record the table of allocations to the various States which appear on pages 11 and 12 of the justification.

(The tables are as follows:)

Distribution of grant-in-aid funds for tuberculosis control

State or Territory	1952 obligations	1953 allocations	State or Territory	1952 obligations	1953 allocations
Total	$5,799,514	$5,300,000	New Hampshire	$18,133	$17,100
			New Jersey	140,591	133,400
Alabama	135,499	123,500	New Mexico	43,015	39,000
Arizona	59,288	56,400	New York	407,286	423,200
Arkansas	91,625	86,200	North Carolina	179,291	153,400
California	297,052	283,900	North Dakota	43,426	36,800
Colorado	51,569	43,800	Ohio	252,646	228,700
Connecticut	83,063	73,700	Oklahoma	103,135	88,700
Delaware	23,044	19,500	Oregon	56,923	48,400
District of Columbia	49,807	48,500	Pennsylvania	263,973	267,500
Florida	131,791	111,800	Rhode Island	32,879	28,800
Georgia	189,065	160,300	South Carolina	132,837	112,600
Idaho	18,296	16,800	South Dakota	25,398	22,300
Illinois	284,414	266,500	Tennessee	167,356	151,900
Indiana	121,452	107,900	Texas	193,311	190,900
Iowa	52,023	45,700	Utah	20,123	18,000
Kansas	71,882	56,600	Vermont	20,366	19,200
Kentucky	161,124	144,400	Virginia	175,373	151,400
Louisiana	119,315	104,700	Washington	76,726	67,300
Maine	32,139	29,900	West Virginia	81,391	73,700
Maryland	123,083	105,100	Wisconsin	92,392	85,600
Massachusetts	200,150	172,600	Wyoming	10,986	11,700
Michigan	195,548	171,400	Alaska	78,549	66,600
Minnesota	83,089	71,700	Hawaii	56,535	47,900
Mississippi	138,994	118,000	Puerto Rico	195,123	199,000
Missouri	133,853	123,900	Virgin Islands	11,266	9,500
Montana	23,864	21,800			
Nebraska	38,100	32,300	Total	5,799,514	5,300,000
Nevada	11,355	10,600			

MASS CHEST X-RAY PROGRAM

Mr. BUSBEY. Now on page 3 you discussed the problem of mass chest X-ray campaigns, especially as that problem is related to the metropolitan areas.

Dr. ROBERT J. ANDERSON. Yes.

Mr. BUSBEY. Are they carried on by what are known as the mobile X-ray units?

Dr. ROBERT J. ANDERSON. Yes, sir. It is the mobile teams we have organized of specialists and the equipment which these cities require in order to put on this campaign.

Mr. BUSBEY. How many teams do you have? Incidentally, just what is a "team"?

Dr. ROBERT J. ANDERSON. We have used the term "team" to describe 18 X-ray machines, together with the people who operate those machines, who read the films, who process the films, who supervise the records necessary to notify people if they have the disease, and to help the local staff. The city health departments locally organize the followup services. In other words, it has been an 18 X-ray unit operating team;

PITTSBURGH PROJECT

Mr. BUSBEY. You mentioned starting in Pittsburgh today.

Dr. ROBERT J. ANDERSON. That is right.

Mr. BUSBEY. Do you have an 18-unit team starting in Pittsburgh?

Dr. ROBERT J. ANDERSON. Yes, sir. There are 18 X-ray units there and the technicians to operate them, the doctors to read the film, and so forth.

Mr. BUSBEY. Each unit is composed of a mobile X-ray laboratory?

Dr. ROBERT J. ANDERSON. Some of the X-ray units are not housed in buses or vans. Some of them are portable so that we can take them and set them into a factory, an office building, or a school, or a downtown metropolitan store, or the light and power company, or a bank, anywhere where people will naturally convene for purposes of shopping or business—all being good places to set up the unit.

Mr. BUSBEY. I take it that this is the first time you have been in Pittsburgh?

Dr. ROBERT J. ANDERSON. Yes, sir; it is.

Mr. BUSBEY. Now explain for the benefit of the committee, please, the steps in getting this particular program started and completed.

Dr. ROBERT J. ANDERSON. All right, sir.

Mr. BUSBEY. Carry your discussion through to the conclusion, and tell us who will assume the program when you have finished.

Dr. ROBERT J. ANDERSON. All right.

About a year ago, or a little longer ago than that, the city health officer of Pittsburgh expressed an interest in this program and asked for information about it. We supplied him that. He took it back home and talked to the people in Pittsburgh, the Medical Society and Tuberculosis Association and the mayor and city officials, about the program. After they had enough information about the program, they decided they wanted this program.

Then it became necessary to carefully prepare for the public information, the promotional side of the campaign, so people would

turn out for the X-rays. We had to decide where the units would be located. Was there electrical power there sufficient to operate the machine? Would the police let the bus sit on that corner, for example? All of those things had to be carefully investigated before today.

We had to establish a dark room which would be of sufficient capacity to develop the films.

So today, which is the opening public kick-off of the campaign, the first small films, which are about 2½ inches square, were taken.

The program is projected to last until September in order to X-ray the 800,000 people that are expected to respond.

Those films taken today will be developed tonight, read by doctors tomorrow. Those people who have no suspicion of disease in their chests, either in their lungs or their heart or anything else that can be seen in the chest X-ray, will receive a little postal card sent out to them by the city of Pittsburgh, telling them that there was no evidence of disease on their chest X-ray at the present time; however, if they should have symptoms, they should see their doctor and certainly should have an X-ray about once a year.

Then those who have some suspicious findings on the readings of the doctors tomorrow will be called back for a big standard-sized chest X-ray film to make sure the shadow was not an artefact or a piece of clothing or some abnormal shadow which could be explained on some other basis. If the shadow is still there on the big film, then the person is sent a letter telling him that he should see his doctor about this condition.

Incidentally, when the patient comes back for his 14- by 17-inch X-ray we find out who his doctor is, ask the patient who he wants the report to go to in the event anything is wrong.

We send the report to the doctor. We notify the patient, and we notify the Pittsburgh Health Department, and they pick that case up for followup.

Then a record system is set up so that the doctor notifies the central record system about whether that patient showed up in his office for examination. If he did not show up, the Pittsburgh City Health Department nurses will go out and visit that case in his home and ask him to arrange to have an examination by his doctor or by the Pittsburgh clinic if he cannot afford a doctor.

That whole procedure, this procedure of followup, as we call it, the business of getting the patient to the doctor and getting him examined after the suspicious film has been uncovered, will take from 9 to 12 months after the period of the small chest X-ray survey. That is the thing ending in September.

Mr. BUSBEY. You anticipate that it will take you until September?

Dr. ROBERT J. ANDERSON. Yes, sir.

Mr. BUSBEY. To finish your project there?

Dr. ROBERT J. ANDERSON. Yes.

Mr. BUSBEY. What happens after that?

Dr. ROBERT J. ANDERSON. After that, the city health department and the Allegheny County staff provide the hospitalization for these cases, and the outpatient treatment necessary for those that they feel do not need hospitalization, or whom they cannot get into their hospitals. Our team goes out and moves to some other area. The place that we propose to go, or we are in the process of negotiating with right now, is Wilmington, Del.

Mr. BUSBEY. What do you estimate are the costs of putting on this project in Pittsburgh?

Dr. ROBERT J. ANDERSON. I do not have the figure for the Pittsburgh total cost. I mean I do not have it broken down on that basis. The community itself has raised $250,000 as their part of the picture taking and followup operation, exclusive of the hospitalization and the long-continuing services that they will need and they will render these patients.

Mr. BUSBEY. You have to make some kind of an estimate on a project of this kind, do you not?

Dr. ROBERT J. ANDERSON. We have it, sir, and I can supply it for you. I do not happen to have it here.

Mr. BUSBEY. It will be all right to insert it in the record.

Dr. ROBERT J. ANDERSON. All right, sir.

(The information is as follows:)

Cost of communitywide chest X-ray survey Pittsburgh-Allegheny County, Pa., March–August 1953

COST OF PITTSBURGH SURVEY

Local sources, total		[1] $255, 100
County of Allegheny	$75, 000	
City of Pittsburgh	75, 000	
Other municipalities	[1] 50, 000	
Allegheny County TB League	50, 000	
Cancer Society	5, 100	
Public Health Service (estimated)		544, 000
Total survey costs		[1] 799, 100

[1] Includes approximately $8,000 already appropriated by individual municipalities in Allegheny County and $42,000 upon which official action is pending.

INDUSTRIAL CHEST X-RAY PROGRAMS

Mr. BUSBEY. Have not the large industrial concerns and many of the smaller industrial concerns throughout the country inaugurated mass chest X-ray programs?

Dr. ROBERT J. ANDERSON. Many of them have for their employees and, particularly for their preemployment examination, and when an individual would come back from a vacation because of illness. That program does not reach the worker who works in a smaller industry or a small factory. It does not reach the self-employed individual. It does not reach the family of the person who is working. So that this program does not duplicate a program that is going on in a factory.

When we find a factory, for example, that has just had an X-ray survey, we do not go in and X-ray them all over again. We make the equipment available outside the factories for the people who service the factory workers.

Mr. BUSBEY. How many of these mobile units does the Public Health Service operate now?

Dr. ROBERT J. ANDERSON. We have 42.

Mr. BUSBEY. Is that the largest number that you ever had in the program?

Dr. ROBERT J. ANDERSON. Yes, sir.

Mr. BUSBEY. What has been done by the Public Health Service to encourage various private industries to inaugurate and conduct mass chest X-ray campaigns?

Dr. ROBERT J. ANDERSON. There has been a promotional program cooperatively with the National Tuberculosis Association and ourselves and the industrial physicians, who are the men who provide the medical programs in industry, to promote the idea within industry of doing preemployment chest X-ray examinations and periodic examinations thereafter.

Mr. BUSBEY. This is not intended as criticism of your program, but I am interested in learning just what has been done to get these companies to assume that expense themselves instead of looking to the Public Health Service to assume it.

Dr. ROBERT J. ANDERSON. Large plants, like Chrysler, for example, and General Motors and Ford, have established this procedure as I have described it. Du Pont in Delaware has done likewise. It is not an uncommon practice in industry, serving the men who work in the large industries. It has been adopted by them as their own program for that group.

Mr. BUSBEY. What have you done to encourage that kind of thing and thereby reduce the demand on the Federal Government while still accomplishing the end result?

Dr. ROBERT J. ANDERSON. We have worked with the National Tuberculosis Association and representatives from the industrial physicians group on a case-finding committee to formulate a statement which would encourage industrial physicians to establish such programs, and back them up when they sought the support of the management in the institution of such a program.

Our regional office and our own people have worked with State health departments too, first, to go in on a basis of demonstration, taking a State-owned unit, for example, into an industry and showing them what the program will produce. Then the industry may take it over later on after such a demonstration.

Mr. BUSBEY. Have very many of the States inaugurated State mass chest X-ray programs and contracted the work out to private X-ray companies?

Dr. ROBERT J. ANDERSON. Some have, yes.

Mr. BUSBEY. As far as your Division is concerned, there is really no end to this program; it is a continuing program?

Dr. ROBERT J. ANDERSON. There is no other way for the big city to get this job done without some outside help; and it is the big city where the problem resides in tuberculosis. We have not covered all of the cities yet either.

CITIES WHICH HAVE COOPERATED IN PROGRAM

Mr. BUSBEY. What are some of the States and cities that have been doing a commendable job in this field? And just what have they done?

Dr. ROBERT J. ANDERSON. Would you like a list of those?

Mr. BUSBEY. Yes, If you will, just submit it for the record.

Dr. ROBERT J. ANDERSON. Surely.

(The information is as follows:)

List of cities and X-rays taken in mass chest X-ray case-finding program— Mass X-ray surveys

Survey	Number of X-rays taken	Total persons referred for followup
Minneapolis, Minn	306,020	7,784
St. Paul, Minn	129,401	3,461
Washington, D. C	454,130	13,723
Seattle, Wash., metropolitan area	375,933	8,853
Tacoma, Wash., metropolitan area	73,197	1,127
Cleveland, Ohio, metropolitan area	684,763	10,764
Spokane, Wash., metropolitan area	106,962	2,377
Denver, Colo., metropolitan area	326,326	9,783
Boston, Mass	536,012	12,200
Salt Lake City, Utah, metropolitan area	162,854	3,667
San Diego, Calif., metropolitan area	239,585	4,584
Los Angeles, Calif., metropolitan area	1,755,001	39,656
Contra Costa County, Calif	124,118	2,338
Phoenix, Ariz., metropolitan area	176,964	7,436
Albuquerque, N. Mex., metropolitan area	77,329	2,826
Willamette Valley, Oreg	237,229	3,519
Southwest Washington	75,073	1,684
Southern Oregon	68,375	1,451
Portland, Oreg., metropolitan area	237,970	5,381
Dallas, Tex., metropolitan area	288,327	5,624
Worcester, Mass., metropolitan area	153,510	3,460
Calcasieu and Cameron Parishes, La	54,305	792
Fresno, Calif., metropolitan area	165,730	[1]
Charlotte, N. C., metropolitan area	106,821	1,782
Pittsburgh, Pa., metropolitan area	[2] 500,000	[1]
Limited resurveys conducted in Washington, D. C., and Cleveland, Ohio	265,366	[3] 1,606
Limited survey assistance between large city operations in Oak Ridge, Tenn.; Fall River, Mass.; Bangor, Brewer, South Brewer, Waterville, and southwestern Maine; San Mateo and Yole Counties, Calif	[3] 140,567	[3] 1,141
Demonstration mass surveys in Savannah, Ga.; Columbus, Ga.; Gaston, Wayne, and Cleveland Counties, N. C., and Milwaukee, Wis	422,140	[3] 5,771
Total	8,244,008	[4] 162,790

[1] Survey in progress.
[2] Estimated number through June 30, 1953, in progress.
[3] Data incomplete as of this date.
[4] Incomplete; see footnotes above.

COOPERATION OF NATIONAL TUBERCULOSIS ASSOCIATION

Mr. BUSBEY. Does the National Tuberculosis Association contribute to this program?

Dr. ROBERT J. ANDERSON. Yes, sir. Their field staff and their local affiliates are all a part of this program. Their staff helps organize the program, and in local communities they help finance the local share of the program, and they help to follow up on the cases that are discovered.

TOTAL CHEST X-RAYS TAKEN IN UNITED STATES, FISCAL YEAR 1953

Mr. BUSBEY. How many diagnostic X-rays are taken per year by others than the Public Health Service? Are any figures available on that?

Dr. ROBERT J. ANDERSON. The only figures I have, sir, are those that relate to X-rays similar to this type taken in this program we are talking about here. We estimate in 1953 there will be a total of 12.6 million X-rays of this small-film type taken throughout the United States. Of those the Public Health Service will take about 1.4 million on the programs I have described.

Mr. BUSBEY. Has there been any thought given to the possibility of having these large cities reimburse the Public Health Service for your mass X-ray work?

Dr. ROBERT J. ANDERSON. No, sir, we have not asked them to do that. We have asked them to contribute about one-third of the cost to initiate their part of the followup program.

Mr. BUSBEY. Do you not think that ought to be explored?

Dr. ROBERT J. ANDERSON. We have a difficult time with the pressures of getting organized for a program to raise, for example, the $250,000 in Pittsburgh.

There is but one city, sir, that I know of that has put on a program of somewhat similar nature all by itself, and that was Erie, Pa., a number of years ago.

EFFECTIVENESS OF NEW DRUG ISONIAZID

Mr. BUSBEY. I am sure it will be disappointing to many people to learn that this new drug isoniazid has not come up to the expectations we had for it a year ago.

Dr. ROBERT J. ANDERSON. I do not mean to leave the impression it is not going to be a useful drug. It will be. In the ordinary garden variety of pulmonary tuberculosis, the results that we have observed in our studies so far show only slight, if any, advantages for the treatment over streptomycin and para-aminosalicylic acid from the standpoint of X-ray improvement; from the standpoint of making patients sputum negative, and so on.

There are experiences, which we happen not to have had, which show the drug has been most useful and a decided improvement in cases of tuberculous meningitis. There this new drug is really very useful.

Mr. BUSBEY. Have you come across situations in which, after a patient has been treated for a while with this new drug, the effect of the drug wears off and it loses effectiveness?

Dr. ROBERT J. ANDERSON. Yes. The tubercle bacilli in cases where the drug does not work ultimately become no longer susceptible to the drug, and we call them resistant. They are resistant strains of bacilli that develop, and the drug is not effective. Fortunately that is not a large percentage when the drug is used in combination with other tuberculosis drugs.

FUNDS REQUESTED FOR 1954

Mr. BUSBEY. Your request for fiscal year 1954 is for $7,645,000?

Dr. ROBERT J. ANDERSON. Yes, sir.

Mr. BUSBEY. And that is a decrease of $595,000?

Dr. ROBERT J. ANDERSON. Yes, sir.

Mr.BUSBEY. What did you ask the Bureau of Budget for originally?

Dr. ROBERT J. ANDERSON. $8,482,000, sir.

Mr. BUSBEY. This decrease is due entirely to a decrease in salaries and expenses; the grants to the States remain the same—$5,300,000?

Dr. ROBERT J. ANDERSON. Yes, sir.

RADIOLOGICAL HEALTH SERVICES

Mr. BUSBEY. On page 16 you have a paragraph on radiology. Under the appropriation "Engineering, sanitation and industrial hygiene", there is a request for $355,000 for radiological health services. What is the reason for both?

Dr. ROBERT J. ANDERSON. This work described here on page 16 relates to the protection of our own personnel from the irradiation to which they are constantly exposed in taking these X-rays in the mass survey operation. It also relates to the determination of the kind and types of equipment that are best suited for this mass X-ray case-finding program.

We have worked cooperatively with the Bureau of Standards and other Federal agencies to develop and publish specifications for X-ray equipment for Federal purposes. This is not a radiation program for the United States; this is in connection with our own X-ray technicians.

Mr. BUSBEY. That is entirely different from the item on radiological health services under engineering, sanitation and industrial hygiene?

Mr. HARLOW. Yes.

Mr. BUSBEY. What is this $355,000 for?

Mr. HARLOW. That relates more largely to the problem of atomic energy as it affects such things as streams and the use of isotopes that are shipped out from the Atomic Energy Commission and that people are not familiar with and do not know how to handle. And the miners who work in uranium mines, and things like that.

Mr. BUSBEY. Do they do anything regarding X-ray?

Mr. HARLOW. No, sir.

Dr. ROBERT J. ANDERSON. Our people are working on the business of making sure that our own X-ray technicians do not incur excessive exposure to the X-ray machines with which they are working, so that we can reduce Government liability for any damage that might occur.

FEDERAL ASSISTANCE AFTER COMPLETION OF A CITY MASS CHEST X-RAY PROGRAM

Mr. BUSBEY. After you finish your program in Pittsburgh in September, what type of Federal personnel are furnished to follow up the mass chest X-ray program?

Dr. ROBERT J. ANDERSON. There are nurses, record workers to help supervise the followup of the cases there. Those will be the types of personnel that will be required. It will be technical personnel.

Mr. BUSBEY. How many positions would that amount to?

Dr. ROBERT J. ANDERSON. I do not have that for Pittsburgh, sir.

Miss HOFF. We have six positions provided for the year.

Dr. ROBERT J. ANDERSON. There are six positions provided for the entire year. I do not know what proportion of those would be involved in Pittsburgh itself. I do not have that figure yet. There are other people that we pick up locally. We canvassed the entire field in the Pittsburgh area to find local people who will be hired through a contractual arrangement for assistance in the immediate followup, the first-term followup of these cases discovered in the chest X-ray survey.

Mr. BUSBEY. How long will Federal employees stay after the X-ray equipment has left the city?

Dr. ROBERT J. ANDERSON. A maximum of 9 months, sir.

Mr. BUSBEY. Then the community takes over the program entirely after that 9 months?

Dr. ROBERT J. ANDERSON. They are always completely in charge, but we help them as long as 9 months after the X-rays.

STAFF FOR ADMINISTRATIVE SERVICES

Mr. BUSBEY. I notice there is a 12 percent reduction in total personnel but that no reduction in the personnel engaged in administration is contemplated. Would you like to comment on that?

Dr. ROBERT J. ANDERSON. Our administrative service activities include my own office together with the central administrative services of personnel, purchase and supply, and keeping these X-ray teams going. With the program as it is proposed here, we need roughly the same staff that we have had before. These people are constantly on the road, Mr. Chairman, and the X-ray teams are constantly on the road, and we need to meet their needs for supplies and equipment. Also, if we do not get their checks to them, we hear about it.

Mr. FOGARTY. Doctor, this Committee cut your request a year ago by $315,000, of which $300,000 was applied against the grants-to-States program. What happened to the appropriation when it reached the Senate?

1953 APPROPRIATION FOR RESEARCH ON ISONIAZID DRUG

Dr. ROBERT J. ANDERSON. After the committee action here, the Senate heard the appropriation request, and it was at that time that the new drug, the isoniazid, was announced. We requested a supplemental of $200,000 to conduct the drug studies which I have described to you in cooperation with the 22 non-Federal Governmental groups. The Senate, in taking action on the total appropriation request, reduced the grant-in-aid activity by the $200,000 which they then made available for the purposes of the drug study.

Mr. FOGARTY. In other words, they just took that $200,000 from the grant appropriation and said, "With this $200,000 you do some research on this new drug"?

Dr. ROBERT J. ANDERSON. Yes, sir.

Mr. FOGARTY. Have you used all of that $200,000 on research?

Dr. ROBERT J. ANDERSON. On the drugs; yes, sir. In fact, there is more than that going into the research program on drugs. The exact figure I cannot give you offhand, but it is in excess of $200,000.

RESPONSIBILITY FOR HEALTH PROGRAMS

Mr. FOGARTY. Now the problem of grants and assistance to States, and their ability to assume more responsibility than they are at the present time is a problem that has bothered me too, and I agree with the chairman to some extent in his contention that the States should gradually assume more of their responsibility in this field. But I just cannot understand how we can make a definite decision, especially in the public-health field, because anything we do in public health affects all the people; does it not?

Dr. ROBERT J. ANDERSON. Yes, sir.

Mr. FOGARTY. There is no one class, the rich or poor, the farmer or laborer, or the employee or employer. It affects everybody. Anything we do on a Federal level or a State level in these programs helps in the long run to improve the health of all the people of the country.

Dr. ROBERT J. ANDERSON. Yes.

Mr. FOGARTY. So it is not a program to help one segment of our industry or one group of our people; it affects everybody who pays taxes and everybody who does not.

I think it is a difficult decision to make. I think the States ought to assume more than they are. But at the same time I would not want to be a party to saying, for instance, that we will not give $5,300,000 for grants to States for tuberculosis-control activities. I do not think anyone in this country could tell us whether or not these activities would be carried on by the States to such a degree as they are now carried on if it were not for this Federal health program. Do you know whether they would or not?

Dr. ROBERT J. ANDERSON. I do not know, sir, either. The grant has shrunk in the past. Our maximum grant was in 1947 with $6,880,000.

Mr. FOGARTY. I am thinking about the malaria and typhus programs. We have practically eliminated malaria and typhus in this country; have we not?

Dr. DEARING. Mr. Chairman, we did eliminate malaria. We used the brave word "eradicate", and malaria has been eradicated as a public-health problem through the efforts, the activities of the Federal Government almost exclusively, in very large measure during the war.

As we interpret, within the Public Health Service and the public health field, the will of the people as expressed through Congress and State legislatures, the Federal-grant program for health services is based on the fact that health is more than a local or individual interest, that ill health in one State affects that of the neighboring State; and that, therefore, the objective has been to stimulate and to take whatever steps may be properly taken by the National Government through grants in aid and through technical assistance to help to assure a minimal level in every State in the areas where something can be done by public activity without regard to their own lack of interest or lack of appreciation of the problem.

National interest as I take it, has been held by the Congress over the past thirty-odd years since health grants started, to override to the extent lack of local interest. The Nation as a whole could not afford to completely ignore health problems any place.

May I say also that the system has been developed jointly as a partnership between the Federal technical people and the State technical people, with the backing and the continual review by the Congress and by the State legislatures. Obviously, the division of labors could have been different in many areas. The States might have taken complete responsibility for laboratory services, with the Federal taking more responsibility for technical development and certain other types of personnel.

Certainly we technicians are subjecting it to continual review and feel the public, through the Congress and State legislatures, should likewise subject the program to continuing review.

What we do feel very strongly is that a sudden change, a revolution, or very substantial shift on the part of the Federal Government would have disastrous results in some areas where over the past years, and at present we are continuing to make some real progress. If the bases of support are to be changed, and that is finally a matter for public decision, especially on problems of financing and tax base and

total national interest, it should be done with a full awareness on the part of the Congress of the consequences which we, as technical people, can see.

If changes could be made in any direction, the decision is finally with the public, but we as technicians can only point out the serious results and destruction through loss of personnel, interruption of services, discontinuance of some services which could not immediately, in some case, be picked up. The public would suffer. Maybe eventually services that were discontinued would be picked up but, from the standpoint of the health of the people, particularly in this time when manpower is one of our greatest shortages, changes should be made with some forecasting and with some degree of of gradualness. It is the sudden shift that would throw a lot of things off balance with disastrous results.

Mr. FOGARTY. That is what I am afraid of. Although I agree in principle with the chairman that in some of these programs the States should assume more responsibility, I think it should be on a gradual basis. The gains that have been made in medicine in the last 10 years, in tuberculosis and venereal disease and cancer and other diseases, are not made effective unless you find the patient in time, If you do, many times you can do something for him. If you do not find him in time, it is just too late; is it not?

Dr. ROBERT J. ANDERSON. Yes.

MASS CHEST X-RAY PROGRAM

Mr. FOGARTY. And that is what you people are accomplishing in these mass chest X-rays.

Dr. ROBERT J. ANDERSON. For example, on the new drug——

Mr. FOGARTY. It was this committee that started the mass X-rays, or which gave you the authority through appropriations to send a team into every State in the Union.

Dr. ROBERT J. ANDERSON. Yes.

Mr. FOGARTY. I thought at the time that there were going to be 48, but you say you only have 42.

Dr. ROBERT J. ANDERSON. The States themselves have picked up the program from the standpoint of the less populous areas, the less populous health jurisdictions, and they are covering States county by county and small city by small city in their own organized programs. We have pulled out of that field as they have picked up that program.

The area that is impossible for service in most States is the big-city area.

Dr. DEARING. May I suggest, Mr. Chairman, that if our activities like the mass chest X-ray surveys, in which we have a comparatively small part, were weighed against the total national effort of doing routine X-rays of well persons in industries and small communities and social orders, lodges, and schools, where groups of people are together, our mass X-ray program by this team approach, which can go in and do a large job which could not be done with local resources, is a supplement which permits, in effect, by virtue of the public drive and getting everybody in, an effect which could not be done economically by any city by itself. The city of Pittsburgh could not economically maintain 18 of these units indefinitely for all time. They should not. They could not use them effectively, but they can be

used to do the job there; they can be moved to another place to do a job elsewhere. This produces an effect that would be totally uneconomic to try to do by putting in the same amount of equipment locally.

The same applies in the matter we talked about in the last appropriation in connection with laboratory services.

At least in the developmental stage the laboratory techniques for diagnosing syphilis were very uneven and caused a great amount of difficulty, missed a lot of cases, and so on. Work to bring the laboratory services up to a level of technical excellence and standards was by common consent of the State health people, the universities, the investigators and our technicians, a proper Federal effort which, if left to the 48 different States, or even the one-third of the States which actually had laboratories which were capable of some reasonable varying degree of performance, could not have been done and could not have been maintained.

One could look now at the question of whether more of the responsibility and more of the support should come from the States in an area like that, but it did not start just as a hand-out. It had a very important technical basis in its developmental stage.

Mr. FOGARTY. Tuberculosis is contagious, too, is it not?

Dr. ROBERT J. ANDERSON. Yes, sir.

Mr. FOGARTY. Very contagious.

Dr. ROBERT J. ANDERSON. The one case we find, per thousand X-rays, are highly contagious cases. They are the cases where the sputum is loaded with tubercle bacilli.

Mr. FOGARTY. I think this matter of grants to States is of great concern to many people. Of course, we always have the problem, too, of the Federal taxes that are paid into the Federal Treasury by a State and the Federal funds that are returned to the State.

All of these subsidy programs that the Government is administering at the present time, I think, should be studied and reviewed. The people over the country ought to know what the Government is giving them in the way of grants or handouts, or whatever you want to call them.

I can see why many people in many sections of the country would question subsidies to agriculture, where only a certain group of people in the country benefit, as in the case of the Sugar Act. We are, in effect, paying a hidden subsidy by keeping the cost of sugar high to protect the sugar beet industry in 2 or 3 States in the country. I can see where some would be concerned about the Federal Government appropriating Federal funds for a Mexican labor program that only helps a certain relatively small group of people in the country. But I think this public health program is a lot different from the other subsidy programs.

What we are doing in this field has some bearing on the health of every individual in the country regardless of his economic or social position in the community.

The President has appointed a committee, has he not, to study overall Federal-State relationships? I presume that this would be made a part of that overall study. Does anybody know?

Mr. STEVENS. I understand that is true. I heard Mr. Dodge make some kind of a statement last Saturday about the President's Commis-

sion on Federal-State Relationships. If it is not appointed, it is actively under consideration.

Mr. FOGARTY. I presume that that committee would take into consideration grant-in-aid programs of all kinds.

Mr. STEVENS. I assume so; yes, sir. I do not know the scope or if it has been analyzed or announced. Health is one of the major phases of Federal-aid grants.

Mr. FOGARTY. What do the States say when you talk to them about assuming a greater load?

We have recommended in previous reports, as we did in last year's report concerning the venereal disease program, that the States assume a larger load in the next few years and gradually take over this program. But I did not realize until today that because of the present emergency and this partial mobilization program new problems have arisen which were not contemplated a couple of years ago. I can see where that factor would delay attainment of the objective. But what is the answer of the States when you talk to them about assuming a greater load?

STATE TUBERCULOSIS PROGRAMS

Dr. ROBERT J. ANDERSON. The States have picked up the program ideas which have become available. I can illustrate that by saying that whereas we operate 42 mobile units for the big cities, the States report a total of over 800 X-ray units of a similar kind doing similar jobs in less populous areas in their States.

They have instituted the newer bacteriological techniques of diagnosing tubercle bacilli in their laboratories. They have spread their clinic services, and most of it has been through increasing appropriations to make their tuberculosis program more complete.

Mr. FOGARTY. Is that the way they answer you—that they are obviously assuming this burden, because today they have 800 X-ray units in operation whereas they did not have any 6 years ago?

Dr. ROBERT J. ANDERSON. And they say, for example, that on tuberculosis they have picked up the X-ray program, and they would now like to institute a laboratory program which would involve the use of guinea pigs or test-tube cultures for determining the presence or absence of tubercle bacilli in patients' sputum. If you can do that kind of technique, you can increase your yield of cases found by approximately 30 percent by using these more exacting techniques. And when we say they must pick this up, they say, "We are just going to have to put that plan of ours aside. We cannot develop that this year. It will have to wait until we can seek support elsewhere."

Mr. FOGARTY. I am reminded also of the Hill-Burton Hospital Construction Act. Apparently the States would not provide proper hospital facilities, or it was just impossible for them or their local communities to finance such facilities. That was the reason for the enactment of the Hill-Burton Act 6 or 7 years ago. As a result the Federal Government is still spending $75 million a year on construction of those facilities.

Dr. OTIS L. ANDERSON. I have some information on State appropriations that have been made this year which may be of interest from the standpoint of possible intention of States to expend more money for various purposes, not necessarily in the direction of health.

According to the information I have available, some eight States have made appropriations to date for the next biennium. About four of them have slight increases as follows:

Indiana, last biennium, $1,492,066; next year, $1,595,067.

For Wyoming, the appropriation for next year is $295,156, compared with the past year of $239,540.

Montana, for the next biennium, $631,250, and the past biennium, $550,790.

For South Dakota, the next biennium, $279,357; the past biennium, $228,006.

Two States, I understand, have made the same appropriation for the forthcoming fiscal years.

For New York I do not have the exact amount available, but I understand it will be the same.

For Utah, the next biennium will be, as in the past, $982,800.

Now there are two States that have decreased their appropriation for the next biennium: Georgia, from $4,500,000 to $4,000,000; West Virginia, from $864,830 to $797,500.

One of our concerns has been mentioned by Mr. Harlow when he stated there were 44 States meeting this year to make appropriations and already—8 have made their appropriations, and some 16 will by the end of this month have completed their actions. So we were wondering just what they could do by way of making up any deficits as between their own funds and Federal funds in the forthcoming fiscal year.

Mr. FOGARTY. The fact is that because of the Federal participation in the public health program, as Dr. Scheele stated the other day, we can expect to live 3 years longer than we could expect to 10 years ago, and 8 years longer than we could expect in 1930. As a result of these public health programs, we have a healthier and happier population than we had 20 years ago.

You are showing progress all the time by these new drugs and new techniques that are being developed, and as a result of all of it, all of the people are getting benefits from every dollar we spend, whereas in these other subsidized programs—agriculture, maritime, and so forth—only certain groups of our people are helped.

The program of the Post Office Department, which is strictly Federal in operation, is a service given by the Federal Government to all the people, and we know that that program never pays its way. I do not know exactly what its deficit amounts to a year, but it is several hundred million dollars. However, it still renders a service that is rendered to all people of the country.

So I think there is some distinction between the Public Health Service and its grants to States and the so-called subsidy programs that we have in much of the rest of the Government.

Dr. DEARING. I would like to make one more observation on this matter of how the States feel and what we find in Federal-State relations.

We find there is considerable importance that appears to be attached by the States to the Federal Government's contribution as a manifestation of the national interest. Even though the proportion may be fairly small, sometimes even token, that is a real help, we are told, in having the legislatures and the population of the States appreciate that they ought to do something about their health in

the national interest regardless of their own willingness to live in illness and squalor. It is a matter almost of patriotism, if you will. They are interested in the national welfare, and if the National Government feels it important enough to put something into it, they are really stimulated to bestir themselves and do something.

We think we are fairly well educated when we say they ought to do something, but a national contribution as a manifestation of national interest does have a stimulating effect and almost an educational effect.

Mr. FOGARTY. That is all, Mr. Chairman.

Mr. BUSBEY. I certainly do not want anything I have said here today to be construed to the effect that I am critical of the program or am not appreciative of the wonderful work that has been done and the results already accomplished.

Mr. FOGARTY. I did not for 1 minute imply that. I was just thinking outloud. There is a problem here, and I was just thinking out loud about certain aspects of that problem.

Mr. BUSBEY. But I just cannot forget the serious financial problem confronting the country. We are rapidly approaching our maximum national debt limit of $275 billion. Our goal must be to balance the budget and give the people some tax relief.

Mr. FOGARTY. I am for that too.

Mr. BUSBEY. This is only a small item in the overall budget. I appreciate that. But I am looking at it and all other programs of government with the objective of determining the degree to which the States might be encouraged to assume greater financial responsibility for their administration.

I do not think anyone on this committee entertains any ideas of cutting off the funds of these worthwhile programs of the Public Health Service; but I do insist that we should be working toward the end of making the States realize that some day they are going to have to assume the major part of this responsibility.

I do not know what steps can be taken to bring them to that realization, but I think we ought to be working toward that end.

Mr. HARLOW. Mr. Chairman, I just want to throw the thought out that perhaps this Federal money spent for health brings much more back in Federal taxes than it costs. A man in a tuberculosis sanitarium does not pay any Federal taxes.

Mr. BUSBEY. I think that is not only true in this program but also in many other programs. And since Mr. Fogarty mentioned the deficit of the Post Office Department, I might also say for the record that if I had my way about it there would not be any deficit in the Post Office Department if these people who are getting newspapers and magazines and other second-class mail delivered practically free of cost paid their just share of the cost.

Mr. FOGARTY. I agree with you; I think that budget should be and can be balanced. But the results in the past of attempting to do so on the floor of the House have not been favorable. I have voted in favor of it, but the people this would affect apparently had a pretty good lobby.

WORK OF INDUSTRIAL COMMITTEES IN MASS CHEST X-RAY PROGRAMS

Dr. ROBERT J. ANDERSON. Mr. Chairman you had an interest in how we worked to get industries, for example, to institute these X-ray programs for their employees.

In every survey, as part of the citizens' organization in these cities where we have worked, there has been an industrial committee, upon which have been representatives of the large industries in the community and the labor groups in the community to work out the details of getting the program started.

In Los Angeles, for example, it was the president of the Magnolia Petroleum Co.; in Pittsburgh, Ben Moreell, president of Jones & Laughlin Steel Co., is active in the program. As a consequence of that committee's action during a survey, after our phase of a program is through, frequently those industries will set up their own programs on a continuing basis.

Mr. BUSBEY. Thank you, gentlemen.

WEDNESDAY, MARCH 25, 1953.

ASSISTANCE TO STATES, GENERAL

WITNESSES

DR. JACK C. HALDEMAN, ASSISTANT CHIEF, BUREAU OF STATE SERVICES

DR. OTIS L. ANDERSON, CHIEF, BUREAU OF STATE SERVICES

RICHARD SEGGEL, ASSISTANT EXECUTIVE OFFICER, BUREAU OF STATE SERVICES

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$16,055,000	$16,150,000	$16,315,000
Transferred from "Control of venereal diseases, Public Health Service," pursuant to Public Law 452		50,000	
Transferred to "Salaries and expenses, defense production activities, Federal Security Agency," pursuant to Public Law 253	−20,000		
Adjusted appropriation or estimate	16,035,000	16,200,000	16,315,000
Reimbursements from non-Federal sources	3,381		
Reimbursements from other accounts	196,757	171,900	161,000
Total available for obligation	16,235,138	16,371,900	16,476,000
Unobligated balance, estimated savings	−18,961		
Obligations incurred	16,216,177	16,371,900	16,476,000
Comparative transfer from—			
"Control of venereal diseases, Public Health Service"	103,000		
"Control of tuberculosis, Public Health Service"	154,263		
"Engineering, sanitation, and industrial hygiene, Public Health Service"	55,918		
"Salaries, expenses, and grants, National Cancer Institute, Public Health Service"	43,930		
"Salaries, expenses, and grants, National Heart Institute, Public Health Service"	34,415		
"Dental health activities, Public Health Service"	9,827		
"Commissioned officers, pay, and so forth, Public Health Service"	371,127		
Comparative transfer to "Salaries and expenes, Public Health Service"	−25,476		
Total obligations	16,963,181	16,371,900	16,476,000

NOTE.—Reimbursements from non-Federal sources above are from the proceeds of sale of personal property (40 U. S. C. 481 (c)).

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
Direct Obligations			
1. Grants to States for general health	$13,500,000	$13,000,000	$13,000,000
2. Direct operations:			
(a) Technical assistance to States	2,076,530	2,035,900	2,026,000
(b) Vital statistics	1,083,395	1,056,900	1,182,000
(c) Administration	106,499	107,200	107,000
Total direct obligations	16,766,424	16,200,000	16,315,000
Obligations Payable Out of Reimbursements From Other Accounts			
2. Direct operations:			
(a) Technical assistance to States	63,587	10,900	
(b) Vital statistics	133,170	161,000	161,000
Total obligations payable out of reimbursements from other accounts	196,757	171,900	161,000
Total obligations	16,963,181	16,371,900	16,476,000

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Summary of Personal Services			
Total number of permanent positions	610	581	618
Full-time equivalent of all other positions	8	6	5
Average number of all employees	518	533	560
Average salaries and grades:			
General schedule grades:			
Average salary	$4,323	$4,402	$4,291
Average grade	GS–5.9	GS–6.0	GS–5.6
Crafts, protective, and custodial grades:			
Average salary	$3,358	$3,389	$3,389
Average grade	CPC–4.8	CPC–4.6	CPC–4.6
Ungraded positions: Average salary	$3,646	$4,045	$3,990
Personal service obligations:			
Permanent positions	$2,692,866	$2,696,299	$2,772,075
Part-time and temporary positions	32,368	23,965	21,485
Regular pay in excess of 52-week base	7,591	7,411	7,715
Payment above basic rates	2,617	1,500	1,500
Total personal service obligations	2,735,442	2,729,175	2,802,775
Direct obligations			
01 Personal services	2,601,782	2,601,275	2,685,775
02 Travel	182,309	175,495	174,995
03 Transportation of things	23,655	17,950	17,960
04 Communication services	23,298	21,950	21,950
05 Rents and utility services	67,383	61,400	71,400
06 Printing and reproduction	57,353	62,600	78,600
07 Other contractual services	29,968	23,125	23,125
Purchase of vital records transcripts	171,400	171,000	171,000
08 Supplies and materials	53,386	45,070	45,270
09 Equipment	52,941	17,400	22,100
11 Grants, subsidies, and contributions	13,500,000	13,000,000	13,000,000
13 Refunds, awards, and indemnities	57		
15 Taxes and assessments	2,892	2,725	2,825
Total direct obligations	16,766,424	16,200,000	16,315,000
Obligations Payable Out of Reimbursements From Other Accounts			
01 Personal services	133,660	127,900	117,000
02 Travel	24,830	700	700
04 Communication services	21		
05 Rents and utility services	32,777	38,000	38,000
06 Printing and reproduction	3,361	3,800	3,800
07 Other contractual services	2		
08 Supplies and materials	1,608	1,500	1,500
09 Equipment	133		
15 Taxes and assessments	365		
Total obligations payable out of reimbursements from other accounts	196,757	171,900	161,000
Total obligations	16,963,181	16,371,900	16,476,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$338,730	$300,470	$525,470
Obligations incurred during the year	16,216,177	16,371,900	16,476,000
	16,554,907	16,672,370	17,001,470
Deduct:			
Reimbursable obligations	200,138	171,900	161,000
Adjustment in obligations of prior years	33,754		
Unliquidated obligations, end of year	300,470	525,470	615,470
Obligated balance carried to certified claims account	1,787		
Total expenditures	16,018,758	15,975,000	16,225,000
Expenditures are distributed as follows:			
Out of current authorizations	15,769,221	15,710,000	15,815,000
Out of prior authorizations	249,537	265,000	410,000

Mr. BUSBEY. The committee will come to order.

We have before us for consideration this afternoon the appropriation request for fiscal year 1954 for the general assistance to States program of the Public Health Service.

Dr. Haldeman, I believe you have a general statement to make at this time.

Dr. HALDEMAN. Yes, sir, Mr. Chairman.

Mr. BUSBEY. You may proceed.

GENERAL STATEMENT

Dr. HALDEMAN. Mr. Chairman and members of the committee, the appropriation, "Assistance to States, general," provides funds for a variety of basic public-health activities which are carried out cooperatively with State and local health departments.

STATE RESPONSIBILITY FOR PUBLIC HEALTH SERVICES

The central concept of our Federal-State programs is that the provision of public-health services is primarily the responsibility of States, counties, and cities, while one of the major roles of the Federal Government is to assist them in this effort. One form of assistance provided is the granting of funds to States. Eighty percent of this appropriation, or $13 million, will be paid directly to States. There these funds are commingled with State and locally appropriated moneys to jointly finance the "backbone" personnel and organization of State and local health services.

The programs conducted by these health agencies are determined locally and are those considered by the people themselves to be necessary for the protection and promotion of their public health. This grant helps to support the basic foundation of this country's public-health system. It helps to support the activities of the health officer himself, both at State and local government levels, the public-health nurses, the sanatorium and sanitary engineers; the laboratory services; vital statistics; and many other basic State and local public-health functions.

These grant funds help to provide the public-health protection which communities have found can best be secured through organized community action rather than through individual action. This includes

such things as immunization programs, public-health education, public-health nursing, and milk, water, and food sanitation. It assists the people to understand their own health problems and encourages them to secure early care and treatment from their family physicians.

This basic organization of personnel and services also serves as the framework to which can be added, as local conditions warrant, such specialized services as tuberculosis control, cancer control, and maternal and child-health services. In times of war or disasters of major importance the basic public-health organization supported by these grants is indispensable to immediate action. It serves as a framework around which emergency health and sanitation services are built.

The necessity for these services continues as the healthfulness and longevity of our people increase, for these services guard us against disease and maintain a healthy people. They prevent disease rather than cure it when it occurs.

FEDERAL HEALTH GRANTS RELATED TO STATE AND LOCAL FUND SUPPORT

I would like to comment briefly on the financing of this cooperative health program and on the significance which Federal grants have in its support. Perhaps this can best be illustrated by considering the role of health grants from all Federal sources—except those for hospital construction—in the financing of programs of State and local health departments and mental-health authorities.

During the fiscal year 1951, the last year for which we have complete figures, these grants amounted to 22 percent of all expenditures for State and local public-health programs. Among individual States, however, there are wide variations in the ratio of Federal funds to total expenditures. This variation ranges from 8 percent to 79 percent. The percentage of Federal participation exceeds the national average of 22 percent in 40 States, and in 16 States it is 40 percent or more.

As you know, there is considerable disparity in the financial ability of States to support needed public-health programs. Moreover, many public-health problems are most severe in States with the lowest resources. Because of the per capita income weighting of the grant allotment formula, the ratio of Federal support of health services is higher in the poorer States than in the wealthier States. Our data indicate that this practice has not resulted in a slackening of effort on the part of these States with low purchasing power. On the contrary, it is generally true that the low-income States are devoting a greater percentage of their financial resources (their own State and local funds) for public-health purposes than are the wealthier States. Hence, the benefit of Federal health grants is greatest in those States which are now putting forth the greatest State and local financial effort, and which have the most acute public health problems.

DIRECT ASSISTANCE OF FEDERAL GOVERNMENT

In addition to grants, there are certain direct activities of the Public Health Service included in this appropriation. I have reference to such things as professional and technical consultation to States, training of personnel, and pilot studies or demonstrations designed to develop better methods to solve public-health problems needing more

effective and economical techniques. These are designed to help States and communities provide more adequate and effective public-health services. They directly complement and are an essential corollary to the grant method.

This assistance furnishes to States the latest technical information based on the results of public-health research, investigations, and the findings from our pilot studies and demonstrations. It is a service which reduces to a minimum the time lag between the development of new knowledge and its application by State and local health agencies. It enables public-health workers in States to take advantage of the experience and thinking of others, including the "pooled" experience and thinking of other States as well as that of the Federal Government. At the same time it permits them to retain independence of decision and action.

PILOT STUDIES

This portion of the appropriation also supports pilot studies and demonstrations designed to develop and test new public-health techniques. This is a type of development and testing familiar in business as well as in Government. Techniques of operation are perfected in 1 or 2 pilot installations before the operation is recommended for adoption on a broad basis. The results of these studies accrue to all States and communities. Pilot studies are carried out in the fields of diabetes, home care of the chronically ill, and medical rehabilitation. These are fields in which the urgency of the problems dictates the need for the early development of suitable public-health techniques.

SERVICES OF NATIONAL OFFICE OF VITAL STATISTICS

Another major activity under this appropriation consists of the services of the National Office of Vital Statistics. This office is responsible for the collection and analysis of data pertaining to births, deaths, and communicable diseases. These vital statistics are basic to the planning, evaluating, and carrying out of public-health programs. They provide the guidepost for States and communities in directing their personnel and funds economically into the most productive activities, and in redirecting their programs for optimum results. Current data are, therefore, of paramount importance if wasteful timelags in program planning and evaluation are to be avoided.

In vital statistics, the Public Health Service provides a direct Federal service. State and local health agencies collect the certificates and other returns which are the sources of our vital data. The Federal Government produces the national statistics which provide reliable comparisons from county to county, State to State, or between our own conditions and those in other countries. Since 1947 the amount of funds available for our vital statistics operations has actually decreased. At the same time the costs of operation—salaries, tabulating cards, printing, supplies—have all risen sharply. Likewise the number of births has increased greatly during this period, adding millions of certificates to the coding and tabulating process. The result has been that we are now a year behind our 1947 publication schedules and are falling farther behind all the time. All possible

economies of operation have been introduced even to the point of postponing processing of essential tabulations.

Requests for vital statistics are received daily from a wide variety of sources. Not only are State and local health departments dependent upon these data, but they are also in demand from other Federal agencies, voluntary health organizations, publishers, workers in research and science, departments of education, and business firms.

Some examples of our dependence upon vital statistics occur where they might be least expected. Pharmaceutical houses for years have used Public Health Service statistics of diseases in estimating demand for their products. The newly discovered value of gamma globulin—a derivative of human blood—in relation to the prevention of poliomyelitis has created a similar but more official dependence upon current data on illness and deaths. The available supply of gamma globulin for use in the coming polio season is only a small fraction of anticipated demand. The Office of Defense Mobilization has taken steps to insure equitable distribution. The National Office of Vital Statistics has been called upon to collect and analyze the data to be used as a basis of allocation to States and communities.

One example will perhaps illustrate the difficulty caused for health administrators by lack of current data. You may recall the recent interest in the association between the use of chloromycetin (one of the new antibiotics) and the occurence of aplastic anemia—a condition which is frequently fatal. Current death certificate data would have been especially valuable in this investigation. Unfortunately, how ever, our latest detailed tabulations by causes of death were for1949—a period prior to the extensive use of chloromycetin.

Official United States Life Tables are published after every census. They are important tools not only to the insurance business, but also to the courts and to anyone who needs to project population estimates. Nevertheless, we have not even begun to construct the tables for the 1950 census period, because of the delays in the processing of mortality statistics.

BUDGET INCREASE

The budget before you provides for an increase for the vital statistics activity. This increase in base will enable us to overcome our present deficiencies and maintain our essential publications on a current basis after June of 1955. This is the only item under this appropriation in which we are proposing an increase for fiscal year 1954 and it is an increase which is most urgently needed.

I will be glad to attempt to answer any questions you may have about the appropriation.

FEDERAL GRANTS RELATED TO TOTAL PUBLIC-HEALTH EXPENDITURES

Mr. BUSBEY. Doctor, I was very pleased to see early in your statement your emphasis on the responsibility of States, counties, and cities in this program.

I was interested in your comments on page 3 in regard to the variance between States in the relationship of Federal funds to total expenditures. It ranges from 8 to 79 percent. What two States make up the extremes?

Dr. HALDEMAN. The low State is New York, and the high State is Alaska.

I have two tables which illustrate the information which was contained on page 3. You can see from this table here that there are several low States: California, with 10.8 percent of Federal funds in their total budget; Illinois, with 11 percent; New York, with 8 percent. However, as I stated, in 16 of the 53 participating States and Territories, it is over 40 percent.

You will also notice in many of the poorer States the percentage of Federal funds is substantial, and these are, of course, States with the greatest health problem: For instance, Alabama with 34 percent; Arkansas with 48 percent; and Mississippi with 47 percent.

Mr. BUSBEY. Without objection, we will put these two tables in the record at this point.

(The tables are as follows:)

TABLE 7.—*Percentage which Federal funds constitute of total public health expenditures as reported for fiscal year 1951 by State agencies participating in grant programs* [1]

State	Fiscal year 1951	State	Fiscal year 1951
Total	21.7	Nevada	52.8
		New Hampshire	35.1
Alabama	43.7	New Jersey	43.8
Arizona	45.9	New Mexico	37.7
Arkansas	47.5	New York	8.0
California	10.8	North Carolina	33.8
Colorado	29.9	North Dakota	39.4
Connecticut	21.4	Ohio	22.1
Delaware	42.1	Oklahoma	35.9
District of Columbia	18.4	Oregon	20.7
Florida	24.2	Pennsylvania	18.8
Georgia	34.2	Rhode Island	38.6
Idaho	46.1	South Carolina	49.9
Illinois	10.9	South Dakota	54.1
Indiana	25.9	Tennessee	36.3
Iowa	43.6	Texas	38.0
Kansas	28.9	Utah	35.4
Kentucky	25.9	Vermont	38.3
Louisiana	34.6	Virginia	22.0
Maine	43.0	Washington	17.6
Maryland	15.7	West Virginia	40.5
Massachusetts	21.6	Wisconsin	15.5
Michigan	20.6	Wyoming	59.2
Minnesota	24.7	Alaska	78.9
Mississippi	47.1	Hawaii	21.5
Missouri	32.7	Puerto Rico	22.9
Montana	37.5	Virgin Islands	56.4
Nebraska	34.6		

[1] Excludes amounts identified as general hospital care and hospital construction and expenditures for operation of tuberculosis sanatoriums and mental and chronic disease hospitals.

Source: Report of expenditures for health services—Joint Financial Report Form 11.1 submitted annually by State health agencies to the Public Health Service.

TABLE 2.—*Comparison of the rank position of States with respect to: (1) Expenditures of State and local funds for public health as related to income payments to individuals, (2) per capita income, and (3) percentage which Federal-grant funds constitute of total public-health expenditures*

State	State and local expenditures for public health in relation to income payments to individuals [1]		Per capita income [2]		Percentage which Federal-grant funds constitute of total public-health expenditures [3]	
	Percent of income payments in 1951	Rank position of State	Per capita income, 1951	Rank position of State	Percent for 1951	Rank position of State
	Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
United States	0.075		$1,584		21.7	
Maryland	.167	1	1,714	15	18.6	43
Kentucky	.142	2	1,066	43	25.9	32
District of Columbia	.136	3	2,095	1	18.4	44
Georgia	.128	4	1,103	42	34.2	27
Virginia	.127	5	1,295	37	22.0	37
Mississippi	.117	6	771	49	47.1	6
New York	.110	7	1,996	5	8.0	49
North Carolina	.108	8	1,052	45	33.8	28
Louisiana	.103	9	1,135	41	34.6	25
Florida	.101	10	1,284	38	24.2	35
California	.097	11	1,933	6	10.8	48
Illinois	.090	12	1,928	7	10.9	47
Washington	.088	13	1,755	10	17.6	45
New Mexico	.086	14	1,301	35	37.7	19
Vermont	.084	15	1,322	34	38.3	17
Tennessee	.081	16	1,064	44	36.3	21
Alabama	.097	17	950	47	43.7	10
Wisconsin	.097		1,614	20	15.5	46
Utah	.077	19	1,424	30	35.4	23
South Carolina	.074	20	1,003	46	49.9	4
Oregon	.071	21	1,652	18	20.7	40
New Hampshire	.070	22	1,444	28	35.1	24
Colorado	.067	23	1,568	21	29.9	30
Arkansas	.063	24	926	48	47.5	5
West Virginia	.058	25	1,174	40	40.5	14
Connecticut	.058		1,999	4	21.4	39
Idaho	.057	27	1,356	33	46.1	7
Pennsylvania	.057		1,663	17	18.8	42
Massachusetts	.057		1,738	12	21.6	38
Oklahoma	.056	30	1,182	39	35.9	22
Delaware	.056		2,076	2	42.1	13
North Dakota	.054	32	1,403	32	39.4	15
Michigan	.053	33	1,734	13	20.6	41
Kansas	.052	34	1,460	27	28.9	31
Minnesota	.051	35	1,474	26	24.7	34
Montana	.049	36	1,742	11	37.5	20
Nevada	.049		2,029	3	52.8	3
Ohio	.048	38	1,799	9	22.1	36
Maine	.048		1,298	36	43.0	12
Indiana	.046	40	1,649	19	25.9	32
Texas	.044	41	1,412	31	38.0	18
Arizona	.043	42	1,432	29	45.9	8
Rhode Island	.042	43	1,691	16	38.6	16
Missouri	.040	44	1,519	24	32.7	29
Nebraska	.036	45	1,510	25	34.6	25
South Dakota	.027	46	1,529	23	54.1	2
Wyoming	.025	47	1,722	14	59.2	1
Iowa	.019	48	1,531	22	43.6	11
New Jersey	.018	49	1,885	8	43.8	9

NOTE.—Federal grants-in-aid in each case exclude grants for hospital construction.

[1] State and local expenditures for public health as reported annually to the Public Health Service and Children's Bureau on Report of Expenditures for Health Services—Joint Financial Report Form 11.1, related to income payments to individuals as reported in Survey of Current Business, table 4, p. 16, August 1952. Department of Commerce.

[2] Per capita income as reported in Survey of Current Business, table 5, p. 17, August 1952. Department of Commerce.

[3] Calculated from data reported annually to the Public Health Service and Children's Bureau on Report of Expenditures for Health Services—Joint Financial Report Form 11.1.

FORMULA USED IN DISTRIBUTING GRANT FUNDS

Mr. BUSBEY. What is the formula used in allocating funds to the States under this appropriation?

Dr. HALDEMAN. The formula, as in the case of all our Public Health Service grant programs, with a little variation in the hospital-construction program, takes into consideration the population, the financial need, and the extent of the various health problems.

Mr. BUSBEY. How would you break that down percentagewise?

Dr. HALDEMAN. In "Assistance to States, general," 95 percent is the population weighted by the index of financial need, which is the per capita income estimate obtained from the Department of Commerce over the most recent 5-year period. The remaining 5 percent of this appropriation is a reciprocal of the population density for 1951. The other programs have an additional element, of course, on the extent of the specific problem.

Mr. BUSBEY. Is this formula prescribed by law or by regulation promulgated by the Surgeon General?

Dr. HALDEMAN. The Public Health Service Act provides the factors; the weighting of the various factors is prescribed by regulation of the Surgeon General.

RELATIONSHIP BETWEEN LEVEL OF HEALTH SUPPORT AND RECEIPT OF FEDERAL FUNDS

Mr. BUSBEY. Do you plan to continue subsidizing States at the current rate indefinitely?

Dr. HALDEMAN. I think there is a need for Federal grants-in-aid. The need varies a great deal State by State.

If I could refer back to the second table, which you inserted into the record, this table relates to a comparison of the rank position of States with respect to the expenditure of State and local funds for public health as related to income payments to individuals, and per capita income, and the percentage which Federal grant funds constitute of total public-health expenditures.

Columns 1 and 2 relate to the total resources of the individual States which are going into public health, expressed in the percent of the total income payments to individuals. You will notice that there is a variation from Maryland to New Jersey of about nine times.

However, in columns 3 and 4, we show where the same States stand in relation to their per capita income, and you will see that generally speaking the poorer States, such as Kentucky, Georgia, Mississippi, North Carolina, Louisiana, and Florida, rank within the first 12 in the amount of their own money they are putting in. However, in columns 5 and 6, which show the percentage which Federal grants constitute of total public health expenditures, you will see that there are a great many States that at the present time have a fairly large percentage of Federal funds—Mississippi, for example, ranking sixth out of her own resources which she is putting in, still has 47 percent of Federal funds.

I think, Mr. Chairman, the answer to your question is that it will be some time before many of the States are able to take up the gap.

I think there are at least two other factors. One of them is that, although there has been a substantial increase in appropriations of

State health departments over the past 10 years, the increase has been primarily confined to a few States. There has been approximately a $75 million increase in State appropriations, but 78 percent of that increase has been concentrated in 9 States and 89 percent in 16 States.

Mr. BUSBEY. I noticed the States you indicated as receiving the largest percentage of Federal funds in comparison to their own wealth are the same States that seem to participate more generously than the other States, in all the Federal grant-in-aid programs. I do not think they are getting such a bad bargain. As a matter of fact, you will find that some of those States receive from the Federal Government more in grants alone than they pay in Federal taxes, while other States only receive back 6 or 7 percent of their Federal tax collections. That means to me that those States are not doing anything toward contributing to the defense and other national programs of the United States.

The grant-in-aid programs as now established appear to me to be what might properly be termed "redistribution of the wealth." Of course, we all know what that means.

GRANT APPROPRIATIONS AND EXPENDITURES, 1947–54

How much have grants under this appropriation decreased during the last 5 years?

Dr. HALDEMAN. Federal grants?

Mr. BUSBEY. Yes, sir.

Dr. HALDEMAN. Our Public Health Service grants, excluding hospital construction—from what year do you wish to take it?

Mr. BUSBEY. Start with 1947.

Dr. HALDEMAN. Could we supply for the record the amounts appropriated and the amounts expended for those years?

Mr. BUSBEY. Surely. We will put that table in the record at this point.

(The table is as follows:)

Assistance to States, general—Grants to States

Year	Appropriation	Payment to States
1947	[1] $11,750,000	[2] $11,716,797
1948	[3] 11,217,039	11,172,895
1949	11,214,666	11,212,895
1950	14,200,000	14,081,128
1951	13,540,500	13,540,085
1952	13,500,000	13,499,999
1953	13,000,000	[4] 13,000,000

[1] Adjusted to exclude $2,500,000 justified for increased cancer services, and transferred in 1948 to National Cancer Institute.
[2] Adjusted to exclude amounts paid for cancer.
[3] Does not include $3,000,000 included in "Assistance to States, general" appropriation but identified in appropriation act for mental health.
[4] Estimated; $10,582,979 as of Mar. 25, 1953.

Mr. BUSBEY. Now your appropriation request for fiscal year 1954 is $16,315,000; is that right?

Dr. HALDEMAN. Yes, sir.

FUNDS REQUESTED OF BUDGET BUREAU

Mr. BUSBEY. And what did you ask the Bureau of the Budget for?

Dr. HALDEMAN. $17,010,000.

Mr. BUSBEY. This request amounts to $165,000 more than the 1953 appropriation?

Dr. HALDEMAN. It amounts to $115,000, I believe, over the 1953 estimate.

Mr. SEGGEL. There is a $50,000 transfer in 1953 from the appropriation, "Control of venereal diseases," in connection with the pay increase for commissioned officers.

BUDGET INCREASE FOR OFFICE OF VITAL STATISTICS

Mr. BUSBEY. You think then that you have to have this increase from 195 positions to 235 positions to take care of the backlog of work in connection with vital statistics?

Dr. HALDEMAN. We think that is very important, Mr. Chairman.

Mr. BUSBEY. Even if you should get these additional positions, the backlog would not be caught up to where you would consider it current until 1955?

Dr. HALDEMAN. That is right, sir. And even then we are postponing a number of types of tabulations and reports for several years until the backlog is caught up and we are able to address ourselves to them.

DESCRIPTION OF ACTIVITIES

Mr. BUSBEY. I think, without objection, we will put the general statement appearing on pages 24, 25, 26, and the top of page 27, in the record.

(The general statement is as follows:)

GENERAL STATEMENT

This activity is described under the subprojects of (*a*) consultative services, (*b*) training, and (*c*) chronic-disease studies.

(A) CONSULTATIVE SERVICES

The objective of this subproject is to provide States and communities with the expert professional and technical consultation which they request to assist them in the development, operation, and evaluation of their locally directed public-health programs. Such consultants include the basic staffs of the 10 regional offices, professional and technical personnel in the central office, and a limited number of personnel detailed to States at their request for special assistance. This estimate provides for the continuation of consultative services at the 1953 level. The basic character of consultation provided from this appropriation requires its maintenance at current levels.

(B) TRAINING

Professionally trained public-health personnel constitute the backbone of health services in this country. We continue, however, to be faced with a critical shortage of such personnel. In response to this situation, this activity provides, through the use of audiovisual aids, lectures, demonstrations, and actual practice, for classroom and field training in general public-health theories, and in the newer standards, techniques, and practices as they are developed through research and field testing. The objectives of this activity are to enable the selected State, local, and Federal personnel receiving this training to perform their tasks more adequately; to enable State and local trainees to assist in training other personnel in their States; and in addition, to increase the supply of trained local, State, and Federal public-health workers.

General-health training is conducted by the Communicable Disease Center at seven regional training centers throughout the United States. State and local health departments are in pressing need of trained health officers, nurses, sanitary engineers, sanitarians, and other public-health personnel. In addition to instruction in schools of public health, these individuals should receive field training in actual public-health practices. Few States, however, are prepared to conduct such training programs either because their facilities are inadequate or because there is not enough demand within individual States to warrant the expenditure of funds. Thus, although during the past year 66 courses have been conducted by the Communicable Disease Center in a total of 392 training weeks (29,719 trainee-days), the requests by States for assistance continue to be greater than can be provided with present facilities.

In addition to training provided at the regional centers, loans of training officers are made to individual States for 1 or 2 years. This program has stimulated at least 12 States to initiate or extend their field training in selected areas of general-health practices. The need for such assignments to States continues.

The program conducted by the Environmental Health Center in Cincinnati is designed: (1) to implement the broadening of public-health programs by giving technical training in specialized aspects of sanitation, and (2) to give expert consultation to State and local health authorities in specialized aspects of environmental health training and to assist them in their own sanitation-training programs.

Concentration on new and specialized problem areas has resulted in a fivefold increase in the number of technical training courses made available at the center. Field assistance to States on their specialized-training activities has increased markedly and will continue to be met within the resources available.

In addition to these training programs, whose emphasis is largely upon State and local personnel, provision is made under this activity for a career-development program for medical officers of the regular corps of the Public Health Service. This program, presently severely limited in the number of officers participating due to the inadequacy of available funds, seeks to maintain and increase the competency of the Public Health Service in the field of public-health administration. The program consists of planned experience for medical officers through rotation of assignments over a 3-year period. These assignments are: (1) One year as a local health officer or assistant health officer assuming the routine and special responsibilities which fall to such a position, (2) one year in a State health department where the officer receives broad experience in health-department operations with particular attention to the work of the Division of Local Health Services, and (3) the remaining year in acquiring a degree of master of public health. This program of planned experience contains the necessary elements to equip a medical officer to discharge reliably the responsibilities of public-health leadership that a Public Health Service officer must assume.

(C) CHRONIC DISEASE STUDIES

Scientific knowledge and techniques are available by which substantial progress can be made in reducing complications of disease and in effecting economies in the care and treatment of patients. Practical methods, however, must be developed to apply such knowledge and techniques in public-health practice. This is done through pilot studies and demonstrations—a type of developmental and testing operation that at a modest cost produces results which can be used by all States and communities. Following are the programs in which the Public Health Service will continue pilot operations as a direct assistance to the States in 1954:

Diabetes is among the 10 leading causes of death in the United States. It is estimated that 2 percent of the population over 15 years of age have diabetes, and that there are approximately 1 million known cases and another million as yet undiscovered. Enough is now known about diabetes to enable practically every diabetes patient to live with the disease and become a productive member of society. This knowledge is available only to known diabetic patients, and early case finding is important so that patients can have medical supervision. The Public Health Service has developed a screening procedure that is an effective and economical case-finding tool, and which has been professionally accepted. Since the incidence of diabetes is growing and it is receiving more attention as a public-health problem, many State and local health agencies request our assistance and guidance in the development, promotion, organization, and improvement of their programs. Our consultants in the medical, nursing, nutritional,

and technical fields assist these health agencies to develop practical programs that are suitable to their particular problems and local conditions.

There are still many unresolved questions regarding the etiology, epidemiology, diagnosis, and management of diabetes that must be answered. We are continuing specific studies and investigations designed to determine prevalence and incidence of the disease and to develop improved methods of detection that are not dependent upon blood glucose and time interval after ingestion of food. Studies are continuing on blood preservatives to determine how blood collected can be shipped without deteriorating to laboratories for testing. We are continuing studies and investigations designed to improve treatment and management of diabetes.

Home care

It is generally accepted that well organized and operated home-care or hospital-extension programs can contribute to the alleviation of the shortage of hospital beds for the chronically ill and in addition provide good care economically. In cooperation with the Commission on Chronic Illness, we are studying a number of representative home-care programs in the United States. The data obtained will provide a basic fund of knowledge which will be used for consultation services to States and local areas and, in addition, for guidance in the development and organization of a home-care-demonstration project in a community of about 100,000 persons. This project will coordinate existing community facilities toward the establishment of a practical home-care program that will serve as a model for other communities.

Medical rehabilitation

Evaluation of the study conducted in cooperation with Gallinger Hospital in Washington, D. C., shows that a large percentage of patients being discharged from hospitals have not been rehabilitated to the point of maximum benefit. This project has demonstrated that many types of patients can be benefited by physical medicine and rehabilitative techniques so that they will spend less time in the hospital and achieve more nearly their maximum functional, social, and economic potential. In addition, this type of restorative service materially reduces the cost to the community for hospital and medical care. Patients are more quickly returned to the status of taxpaying individuals rather than remaining a burden to themselves and the community. In general, many communities are not aware of the great savings in taxes and human resources resulting from a coordinated rehabilitation program. Two carefully selected areas will be used to establish demonstration projects which will combine all the resources of the community to improve restorative services. These areas will demonstrate to physicians, hospital administrators, and health officers the best way to organize and operate a total community rehabilitation program. Audiovisual aids will be developed for use in training medical students, physicians, physical therapists, and occupational therapists in the latest technical developments of physical medicine. It is expected that an increase in the number of requests for advice and assistance in the development and organization of total rehabilitation programs will be received when information regarding results of these demonstrations is more widely distributed.

In order to determine their public-health significance, we are constantly engaged in review and evaluation of chronic-disease problems; abnormalities of sight and hearing, nutritional aspects of the chronically ill and aged, screening tests for mass case finding of chronic diseases, and the health problems associated with the aging process.

RELATIONSHIP OF MEDICAL REHABILITATION WORK TO PROGRAM OF OFFICE OF VOCATIONAL REHABILITATION

Mr. BUSBEY. On page 26 it says, under "Medical rehabilitation":

Evaluation of the study conducted in cooperation with the Gallinger Hospital in Washington, D. C., shows that a large percentage of patients being discharged from hospitals have not been rehabilitated to the point of maximum benefit. This project has demonstrated that many types of patients can be benefited by physical medicine and rehabilitative techniques so that they will spend less time in the hospital and achieve more nearly their maximum functional, social, and economic potential. In addition, this type of restorative service materially reduces

the cost to the community for hospital and medical care. Patients are more quickly returned to the status of taxpaying individuals rather than remaining a burden to themselves and the community. In general, many communities are aware of the great savings in taxes and human resources resulting from a coordinated rehabilitation program.

Two carefully selected areas will be used to establish demonstration projects which will combine all of the resources of the community to improve restorative services. These areas will demonstrate to physicians, hospital administrators, and health officers the best way to organize and operate a total community rehabilitation program. Audiovisual aids will be developed for use in training medical students, physicians, physical therapists, and occupational therapists in the latest technical developments of physical medicine. It is expected that an increase in the number of requests for advice and assistance in the development and organization of total rehabilitation programs will be received when information regarding results of these demonstrations is more widely distributed.

What is the difference between that work and the vocational rehabilitation program?

Dr. HALDEMAN. The vocational rehabilitation—first, I should say this is a cooperative project between the District of Columbia Health Department, the District of Columbia Vocational Rehabilitation Group, as well as the Public Health Service. All three groups have participated in it.

The rehabilitation program takes a number of components—physical rehabilitation, vocational counseling, vocational training, sheltered workshop, and job placement. In this total rehabilitation program we are interested in many types of patients—cardiovascular, accidents, amputations, arthritic patients, spinal-cord injuries—of course, regardless of whether they can be rehabilitated to go back to work or not. So vocational rehabilitation is a portion of the overall rehabilitation program.

The results of this study have shown that the average patient's stay has been considerably reduced. In this particular study it shows it has been reduced from an average stay of 99.5 days to an average stay of 24.74 days in the hospital.

Mr. BUSBEY. On page 24, under "Rehabilitation centers, Office of Vocational Rehabilitation," is the following statement:

> Recognizing that the dearth of adequate rehabilitation facilities is still a major obstacle to extension of services to disabled persons who need them, we plan to aid State and local communities in developing rehabilitation centers. Such consultation will include technical advice on methodology for measuring need for rehabilitation services, recommendation for design, construction, financing, staffing, and equipping rehabilitation centers. In the absence of standards for such facilities and of any established accredited authority, we will stimulate pioneer work in the initial formulation of standards. In cooperation with the Division of Hospital Facilities, Public Health Service, we will also formulate recommended standards for the physical design and construction of rehabilitation facilities in hospitals and for essential elements in such programs.

I am trying to get at the difference in the programs. Why is it necessary for both agencies to be in this field?

Dr. HALDEMAN. I think the principal difference is that in our program we are interested in a total rehabilitation program for a community, whereas the program referred to there is a part of that particularly aimed at individuals who can be rehabilitated to get back on the job. We work very closely with them. We have joint planning in relation to this demonstration here in Washington, and both of our offices have contributed financially to it.

Mr. BUSBEY. The vocational rehabilitation people seem to recognize that the Division of Hospital Facilities has a place in this field, but they do not mention your division.

Dr. HALDEMAN. The total amount of money going into this project is relatively small. They are quite cognizant of it because, as I said, we jointly plan.

TECHNICAL-ASSISTANCE ACTIVITIES OF FIELD STAFF

Mr. BUSBEY. How many people do you have whose basic duty is to travel around to States, cities, and communities to assist with health problems?

Mr. SEGGEL. We have 185 people in consultative services under this appropriation.

Mr. BUSBEY. Under what circumstances do they travel? Do you send them out or do they only go out when a request for assistance is received, or what are the circumstances?

Dr. HALDEMAN. In order to discuss that point, I think we should discuss what the types of people are.

Mr. BUSBEY. Yes.

Dr. HALDEMAN. The largest single group, 126, relate to the basic regional office staff. By basic staff, we mean the regional-medical director, the regional engineer, the regional nurse, public-health representative—the nucleus or basic staff of the regional office.

The Public Health Service operates on a decentralized program as far as its grants-in-aid program is concerned. The Surgeon General has delegated to the regional medical directors the responsibility for approving plans and budgets submitted by the various States. They give the overall type of consultation that is referred to in my opening testimony relating to technical assistance to States.

The next largest category of personnel relates to our training activities. These are activities carried on through our 7 original training centers, as well as on the request of States where we have assigned 7 officers to States.

We also have training programs in communicable disease centers and environmental health centers that are paid out of these funds.

The remainder of personnel relate to personnel located in headquarters that work on the overall aspects of our Federal-State cooperative program.

Mr. BUSBEY. Could you prepare for the record a table showing the number of man-days spent in each State during the last calendar year?

Mr. SEGGEL. We can do it, I think.

Dr. HALDEMAN. It would require analysis of our travel records and could be done.

Mr. BUSBEY. Would you supply that for the record?

Dr. HALDEMAN. Yes.

(The table is as follows:)

Rough estimate of man-days spent in States for technical assistance to States under the appropriation "Assistance to States, general, Public Health Service," during calendar year 1952, by States [1]

States	General consultative services	Special training assistance [2]	Chronic disease studies	Total
Alabama	66		3	69
Arizona	22			22
Arkansas	40		1	41
California	265	446	149	860
Colorado	531			531
Connecticut	36		4	40
Delaware	24			24
District of Columbia	63			63
Florida	81	331	6	418
Georgia	237			237
Idaho	40			40
Illinois	47	137		184
Indiana	41		5	46
Iowa	52			52
Kansas	322	258		580
Kentucky	102	30	2	134
Louisiana	34		166	200
Maine	104			104
Maryland	36	154	10	200
Massachusetts	241		12	253
Michigan	81		5	86
Minnesota	283			283
Mississippi	63			63
Missouri	63			63
Montana	100			100
Nebraska	98			98
Nevada	22			22
New Hampshire	66		1	67
New Jersey	49		2	51
New Mexico	45			45
New York	302	342	12	656
North Carolina	112	524	5	641
North Dakota	70			70
Ohio	63		11	74
Oklahoma	41		6	47
Oregon	46			46
Pennsylvania	133		10	143
Rhode Island	40		2	42
South Carolina	28		4	32
South Dakota	58			58
Tennessee	54			54
Texas	48	262	16	326
Utah	72			72
Vermont	44			44
Virginia	166		5	171
Washington	77	186		263
West Virginia	48		3	51
Wisconsin	50			50
Wyoming	44			44
Alaska	2			2
Hawaii	50			50
Puerto Rico	4			4
Virgin Islands	12			12
Totals	4,818	2,670	440	7,928

[1] Does not include travel time to and from State.
[2] Does not include regional training centers.

Mr. BUSBEY. Do any of your people who are engaged in what you term "administration" have need for Government-owned automobiles?

Mr. SEGGEL. On occasion. We have in this appropriation 24 people under "administration," but we have no specific cars assigned to these particular people.

Mr. BUSBEY. How about those working on vital statistics?

Mr. SEGGEL. They do not have a car specifically assigned. All the automobiles in this appropriation are in the field, regional offices, and so on.

Mr. BUSBEY. That would leave about 325 positions under technical assistance to the States. How many of those positions are filled now?

Mr. SEGGEL. At the current moment, February 28, there are 276 on duty. I should mention, however, that the 324 is a gross position figure. The budget provides for net permanent positions of 303—that is, those which are filled on the average throughout the year.

Mr. BUSBEY. And how many of these current employees are professional and technical?

Mr. SEGGEL. About 2 professional to 1 clerical.

Mr. BUSBEY. What I am leading up to is that you have provision in the 1954 budget for 104 passenger-carrying motor vehicles. Why will you need 104 passenger-carrying motor vehicles?

Mr. SEGGEL. A large number of them are in regional offices and training centers. They do a large amount of traveling. If they do not travel in regional offices, they are not doing a job. Most of them are short trips. Cars in this appropriation are used by divisions that are financed out of other appropriations as well. For example, there are 5 or 7 consultants in regional offices on hospital construction that use these cars.

PUBLIC HEALTH SERVICE MOTOR VEHICLES

Mr. BUSBEY. Mr. Harlow, could you prepare for the record tables showing by Public Health Service appropriation the make and year of manufacture, mileage, and number of miles driven for each car during the first 6 months of fiscal year 1953, and a sentence or two on the specific need for keeping them?

Mr. HARLOW. Yes, sir; we can get that up for you.

(The information is as follows:)

Passenger-carrying motor vehicles on hand as of Mar. 25, 1953 (includes passenger cars, station wagons, ambulances, and buses)

DIVISION OF VENEREAL DISEASE

CONTROL OF VENEREAL DISEASE

Tag No.	Make	Year	Body style	Mileage driven, July 1 to Dec. 31, 1952	Cumulative mileage as of Dec. 31, 1952	Use and location as of Mar. 25, 1953
FS-131	Chevrolet	1950	Sedan	5,268	28,638	Used by VD investigator, Mobile County, Ala.
FS-134	do	1950	do	3,543	17,925	Denver, Colo.: Used by VD consultants to visit State health departments in region 9.
FS-139	do	1950	do	7,669	41,672	Dale and Houston Counties, Ala.: VD investigator.
FS-155	do	1950	do	6,376	24,640	Birmingham, Ala.: VD investigator.
FS-156	do	1950	do	8,919	38,487	Atlanta, Ga.: Used by VD consultants to visit State health departments in region 6.
FS-176	do	1950	do	5,885	36,374	Boston, Mass.: Used by VD consultants to visit State health departments in region 1.
FS-279	do	1948	do	6,745	33,493	Denver, Colo.: Used by VD consultants to visit State health departments in region 9.
FS-874	Pontiac	1948	do	1,339	27,256	Chicago, Ill.: Used by VD consultants to visit State health departments in region 5.
FS-1410	do			6,188	54,614	Washington, D. C.: Used by VD consultants to visit State health departments in region 3.
FS-1701	Ford	1950	do	1,856	19,180	Philadelphia, Pa.: Blood-testing survey.
FS-1712	do	1950	do	3,362	24,106	Fort Bragg, N. C.: VD investigator.
FS-1713	do	1950	do	10,035	53,459	North Carolina north: VD investigator, eastern counties.
FS-1733	do	1950	do	5,422	34,607	Memphis, Tenn.: VD investigator.
FS-1738	do	1950	do	8,013	25,125	Puerto Rico: VD investigator.
FS-1751	do	1950	do	11,336	50,036	Charleston, W. Va.: Research investigator.
FS-1793	do	1950	do	5,452	35,340	Greenwood, Miss.: VD investigator.
FS-1827	do	1950	do	8,926	36,380	Puerto Rico: VD investigator.
FS-1830	do	1950	do	12,082	46,565	Raleigh, N. C.: VD investigator.
FS-1831	do	1950	do	2,996	44,420	Philadelphia, Pa.: Blood-testing survey.
FS-1833	do	1950	do	7,375	43,955	Fort McClellan, Ala.: VD investigator.
FS-1834	do	1950	do	6,320	40,803	San Antonio, Tex.: VD investigator.
FS-1835	do	1950	do	6,070	37,531	Fort Campbell, Ky.: VD investigator.
FS-1844	do	1950	do	6,680	44,580	Augusta, Ga.: VD investigator.
FS-1867	do	1950	do	4,942	28,945	Shreveport, La.: VD investigator.
FS-2122	do	1950	do	3,695	24,752	Detroit, Mich.: Research investigator.
FS-2144	do	1950	Station wagon	11,078	63,148	San Francisco, Calif.: Research investigator.
FS-2224	Pontiac	1950	Sedan	3,058	18,079	Hot Springs, Ark.: Rapid-treatment center.
FS-2225	Chevrolet	1948	do	6,787	40,077	Gainesville, Ga.: VD investigator.
FS-2252	Ford	1950	do	8,473	51,320	San Diego, Calif.: VD investigator.
FS-2281	Chevrolet	1950	do	7,626	50,216	Georgia southeastern counties: VD investiagtors.
FS-2295	do	1950	do	4,982	27,680	Chamblee, Ga.: VD research laboratory.
FS-2303	do	1950	do	9,134	29,089	Cook County, Ill.: VD investigator.
FS-2432	do	1950	do	4,144	21,780	Pittsburgh, Pa.: VD investigator.
FS-2457	do	1948	do	10,524	35,000	Puerto Rico: VD investigator.
FS-2900	Pontiac	1948	do	6,253	59,258	Atlanta, Ga.: Used by VD consultants to visit State health departments in region 6.
FS-2912	do	1948	do	6,218	37,948	Atlantic City, N. J.: VD investigator.
FS-3039	do			3,404	44,015	Kansas City, Mo.: Used by VD consultants to visit State health departments in region 7.

Passenger-carrying motor vehicles on hand as of Mar. 25, 1953 (includes passenger cars, station wagons, ambulances, and buses)—Continued

DIVISION OF VENEREAL DISEASE—Continued

CONTROL OF VENEREAL DISEASE—Continued

Tag No.	Make	Year	Body style	Mileage driven, July 1 to Dec. 31, 1952	Cumulative mileage as of Dec. 31, 1952	Use and location as of Mar. 25, 1953
FS-3063	Dodge	1947	Bus	2,592	87,151	Birmingham, Ala.: Prevention and control center.
FS-3075	Pontiac	1949	Sedan	6,437	58,414	Dallas, Tex.: Used by VD consultants to visit State health departments in region 8.
FS-3076	do	1949	do	4,732	39,648	Hot Springs, Ark.: Used at rapid-treatment center.
FS-3077	do	1949	do	6,274	57,049	Atlanta, Ga.: Used at the prevention and control center.
FS-3078	do	1949	do	4,667	28,984	Washington, D. C.: Used by VD consultants to visit State health departments in region 3.
FS-3079	do	1949	do	1,624	25,148	Cleveland, Ohio: Used by VD consultants to visit State health departments in region 4.
FS-3080	Ford	1949	do	7,004	59,647	Boise, Idaho: Used by VD investigator.
FS-3236	Pontiac	1950	Station wagon	6,154	25,965	Atlanta, Ga.: Used at the prevention and control center.
FS-3248	Chevrolet	1950	Sedan	8,794	34,471	Wilmington, N. C.: Used by VD investigator.
FS-3253	do	1950	do	2,606	26,066	Detroit, Mich.: Used by VD investigator.
FS-3254	do	1950	do	5,146	18,527	Brooklyn, N. Y.: Used by VD investigator.
FS-3255	do	1950	do	4,832	33,057	Huntington, W. Va.: Used by VD investigator.
FS-3256	do	1950	do	5,106	25,806	Montgomery, Ala.: Used by VD representative.
FS-3257	do	1950	do	2,766	14,149	White County, Ga.: Used by VD investigator.
FS-3258	do	1950	do	7,927	30,637	Jackson, Miss.: Used by research investigator.
FS-3259	do	1950	do	8,677	25,016	Puerto Rico: Used by VD investigator.
FS-3260	do	1950	do	3,976	16,275	St. Louis, Mo.: Used by research investigator.
FS-3261	do	1950	do	13,606	49,379	Camp Breckinridge, Ky.: Used by VD investigator.
FS-3267	Ford	1950	do	2,335	28,085	Baton Rouge, La.: Used by VD investigator.
FS-3271	Chevrolet	1950	do	6,952	36,380	Norfolk, Va.: Used by research investigator.
FS-3274	do	1950	do	3,387	19,071	Richmond, Va.: Used by VD investigator.
FS-3278	do	1950	do	4,276	22,833	Montgomery, Ala.: Used at prevention and control center.
FS-3279	do	1950	do	2,427	14,765	Charleston, W. Va.: Used by VD investigator.
FS-3280	do	1950	do	12,522	53,669	Charlotte, N. C.: Used by research investigator.
FS-3281	do	1950	do	2,572	19,438	Charleston, S. C.: Used by VD investigator.
FS-3285	do	1950	do	6,589	19,475	Atlanta, Ga.: Used by VD representative.
FS-3288	do	1950	do	3,318	20,000	Hattiesburg, Miss.: Used at prevention and control center.
FS-3290	do	1950	do	2,867	18,447	Greenwood, Miss.: Used at rapid-treatment center.
FS-3291	Ford	1950	do	6,676	30,294	Gulfport, Miss.: Used by VD investigator.
FS-3921	Pontiac	1949	do	5,607	42,801	Southwest counties of Georgia: Used by VD investigator.
FS-3922	do	1949	do	10,575	58,150	Cleveland, Ohio: Used by VD consultants to visit State health departments in region 4.
FS-3990	Chevrolet	1951	do	6,617	17,992	Bronx, N. Y.: Used by VD investigator.
FS-3991	do	1951	do	4,279	14,068	Manhattan, N. Y.: Used by VD investigator.
FS-3998	do	1951	do	7,065	24,654	Arkansas: Used in the Arkansas Delta plantation survey.
FS-3999	do	1951	do	7,755	24,528	Fort Sill, Okla.: Used by VD investigator.

FS-3998	do	1951	do	7,755	24,528	Fort Sill, Okla.: Used by VD investigator.
FS-3999	do	1951	do			
FS-4062	do	1952	Station wagon	3,782	4,833	Chamblee, Ga.: Used by VD research laboratory.
FS-4091	do	1951	Sedan	6,802	20,268	New York City, N. Y.: Used by VD research investigator.
FS-4092	do	1951	do	10,948	27,202	Window Rock, Ariz.: Used by VD investigator.
FS-4093	do	1951	do	8,020	14,524	Wilmington, N. C.: Used by the prevention and control center.
FS-4094	do	1951	do	5,954	20,406	Detroit, Mich.: Used by VD investigator.
FS-4096	do	1951	do	10,261	27,307	Camp Kilmer, N. J.: Used by VD investigator.
FS-4097	do	1951	do	3,921	10,793	Philadelphia, Pa.: Used by VD investigator.
FS-4098	do	1951	do	5,650	27,048	Fort Dix, N. J.: Used by VD consultants to visit State health departments in region 1.
FS-4099	do	1951	do	7,260	22,310	Boston, Mass.: Used by VD investigator.
FS-4100	do	1951	do	8,600	22,000	Chester, Pa.: Used by VD investigator.
FS-4101	do	1950	do	4,779	13,070	Harlem, N. Y.: Used by VD research investigator.
FS-4112	Ford	1951	do	10,100	45,789	Durham, N. C.: Used by VD investigator.
FS-4145	Chevrolet	1951	do	6,864	19,614	Newark, N. J.: Used by VD investigator.
FS-4146	do	1951	do	8,859	27,025	Trenton, N. J.: Used by VD investigator.
FS-4147	do	1952	do	4,741	8,115	Rochester, N. Y.: Used by VD investigator.
FS-4292	do	1952	do	5,377	5,377	Little Rock, Ark.: Used by VD investigator.
FS-4293	do	1950	do	2,530	2,530	11th Naval District, Calif.: Used by the VD research investigator.
FS-4355	do	1950	do	12,339	41,524	Birmingham, Ala.: Used by the VD research investigator.
FS-7131	do	1951	do	2,281	11,782	Washington, D. C.: Used by VD research investigator.
FS-7137	do			2,822	8,652	Washington, D. C.: Used by VD investigator.

BUREAU OF STATE SERVICES

Control of Tuberculosis, PHS

FS-302	Pontiac	1950	Sedan	1,641	33,931	Columbus, Ga.: Used for epidemiology studies.
FS-1633	do	1950	do	3,366	26,727	Pittsburgh, Pa.: Used for mass X-ray survey.
FS-3282	do	1950	do	10,557	39,031	Do.
FS-3863	Ford	1949	do	2,637	47,173	Do.
FS-3937	Pontiac	1949	do	7,187	47,198	Fresno, Calif.: Used for mass X-ray survey.
FS-3938	do	1949	do	6,613	46,301	Pittsburgh, Pa.: Used for mass X-ray survey.
FS-4068	do	1951	do	2,534	12,233	Philadelphia, Pa.: Used for epidemiology studies.
FS-4078	do	1951	do	1,860	24,610	Fresno, Calif.: Used for mass X-ray survey.
FS-1436	Buick	1947	do		85,000	Rockville: Storage, excess; being disposed of.

Assistance to States, General

FS-145	Ford	1948	Sedan	3,040	36,480	Vessel-inspection activities, Baltimore, Md.
FS-154	Buick	1948	do	1,715	35,748	Occupational-health field studies, Detroit, Mich.
FS-171	Pontiac	1948	do	2,748	41,160	Sanitation surveys, inspections, visits to States, Puerto Rico.
FS-204	do	1949	do	5,380	54,000	Inspections, Hoboken, N. J.
FS-205	do	1949	do	6,041	36,158	Inspections of vessels, Hoboken, N. J.
FS-206	do	1949	do	4,105	36,033	Inspection of hospitals being constructed, New York, N. Y.
FS-211	do	1949	do	4,357	23,800	Medical consultants in serving medical programs, New York, N. Y.
FS-213	do	1948	do	2,300	57,918	Sanitation personnel make inspections, visit States for consultative purposes, Atlanta, Ga.
FS-237	Ford	1949	do	655	81,399	Water studies, Salt Lake City, Utah.
FS-248	Pontiac	1948	do	2,687	54,456	Sanitation personnel make inspections and render consultative services to States, New Orleans, La.

Passenger-carrying motor vehicles on hand as of Mar. 25, 1953 (includes passenger cars, station wagons, ambulances, and buses)—Continued

BUREAU OF STATE SERVICES—Continued

ASSISTANCE TO STATES, GENERAL—Continued

Tag No.	Make	Year	Body style	Mileage driven, July 1 to Dec. 31, 1952	Cumulative mileage as of Dec. 31, 1952	Use and location as of Mar. 25, 1953
FS-249	Pontiac	1948	Sedan	8,422	66,118	Sanitation personnel make inspections and render consultative services to States, Dallas, Tex.
FS-409	do	1948	do	5,899	39,409	Loaned to Atomic Energy Commission, Mercury, Nev.
FS-412	Ford	1949	do	2,992	67,808	Transportation of CDC training students, Atlanta, Ga.
FS-462	do	1947	do	4,640	62,800	Sanitation personnel make inspections and render consultative services to States, Atlanta, Ga.
FS-595	Pontiac	1948	do	6,335	49,908	Sanitation personnel make inspections, render consultative services to States, Houston, Tex.
FS-754	do	1948	do	1,843	28,595	Medical consultants in serving medical programs, Chicago, Ill.
FS-768	Ford	1947	do	3,452	39,535	Vessel-inspection activities, Philadelphia, Pa.
FS-769	Pontiac	1948	do	5,213	52,832	Quarantine activities at Quarantine Station, Rosebank, Staten Island, N. Y.
FS-776	do	1948	do	1,168	30,754	Quarantine activities at Quarantine Station, Kansas City, Mo.
FS-835	Buick	1946	do	3,836	38,888	Mental-health personnel for consultative services, Kansas City, Mo.
FS-847	Ford	1947	do	3,071	66,355	Inspection and supervision of Defense Comm. Facilities projects, Kansas City, Mo.
FS-931	Buick	1947	do	2,894	70,939	Consultative services in Heart Demonstration Unit, Charleston, S. C.
FS-937	do	1947	do	6,007	73,590	Transportation of students, PHS personnel, and training aides, Atlanta, Ga.
FS-945	Ford	1950	do	5,891	55,523	Malaria investigations, Newton, Ga.
FS-973	Pontiac	1950	do	396	30,389	Stored pending sale, Seattle, Wash.
FS-988	do	1950	do	5,064	9,510	Sanitation surveys, inspections, and visits to States to render consultative services, Chicago, Ill.
FS-1009	do	1950	do	5,291	27,250	Regional director in consultation regarding public-health activities, Chicago, Ill.
FS-1018	do	1950	do	4,282	23,956	Engineering personnel make sanitation surveys, inspections, and render consultative services to States, Chicago, Ill.
FS-1027	do	1950	do	2,975	25,762	Consultative services, Boston, Mass.
FS-1052	do	1950	do	5,572	22,366	Do.
FS-1055	do	1950	do	6,192	29,731	Chronic disease personnel for consultation in the States, Washington, D. C.
FS-1063	do	1950	do	389	30,562	Consultative services, Kansas City, Mo.
FS-1243	do	1948	do	8,063	45,583	Hospital facilities personnel to inspect hospitals being constructed, San Francisco, Calif.
FS-1337	do	1950	do	7,957	45,455	Chronic disease, for consultation in States, Atlanta, Ga.
FS-1340	do	1950	do	4,344	43,015	Sanitation personnel make inspections and visit States for consultative purposes, Atlanta, Ga.
FS-1348	do	1950	do	3,801	22,323	Sanitation personnel, inspections and visits to States for consultative purposes, Atlanta, Ga.
FS-1370	do	1950	do	9,359	47,393	Deputy medical director for consultative services, Atlanta, Ga.
FS-1371	do	1948	do	1,668	37,134	Hospital facilities personnel, to inspect hospitals being constructed, Dallas, Tex.
FS-1477	Ford	1950	do		32,917	Sanitation personnel to make inspections of vessels, Hoboken, N. J.
						Epidemiology studies, Chamblee, Ga.

FS-1487	Pontiac	1950	do	2,354	32,443 Engineering personnel make sanitation surveys, inspections, and visit States for consultative services, Kansas City, Mo.
FS-1532	do	1950	do	55	29,550 Regional medical director for consultation concerning medical programs, Cleveland, Ohio.
FS-1638	do	1950	do	7,146	36,041 Medical consultant for consultation in medical programs, Denver, Colo.
FS-1641	Ford	1950	do	1,277	36,866 Consultative services in diabetes, Boston, Mass.
FS-1659	do	1950	do	4,716	19,552 TB personnel for consultation to States, Kansas City, Mo.
FS-1757	Pontiac	1948	do	5,834	65,861 Engineering personnel make sanitation surveys, inspections, and visit States to render consultative services, Mercury, Nev.
FS-1799	Buick	1947	do	924	62,508 Insect-vector control, stored pending disposal action, Atlanta, Ga.
FS-1850	do	1948	do	8,495	51,977 Sanitation personnel to inspect vessels and dining cars, Seattle, Wash.
FS-1961	Pontiac	1948	do	2,489	29,678 Nursing personnel for consultative purposes, Atlanta, Ga.
FS-1978	Ford	1950	do	2,156	24,931 Epidemiology studies, Framingham, Mass.
FS-2279	do	1947	do	10,466	49,604 Declared surplus. Awaiting disposition (mileage through Sept. 15, 1952), Denver, Colo.
FS-2280	do	1947	do	268	61,523 Stored pending sale, Galveston, Tex.
FS-2423	Buick	1947	do	5,094	37,820 Contacting other Government agencies at headquarters, Washington, D. C.
FS-2508	Chevrolet	1948	do	3,582	42,809 Mass X-ray survey, Pittsburgh, Pa.
FS-2509	Pontiac	1948	do	3,007	74,132 Sanitation personnel to make inspections and visit States for consultative purposes, Denver, Colo.
FS-2510	do	1948	do	5,196	42,878 Medical consultant in medical programs, Denver, Colo.
FS-2511	do	1948	do	7,206	49,396 Medical consultant in medical programs, Salt Lake City, Utah.
FS-2533	Ford	1946	do	1,298	47,289 Consultative service in diabetes, Dallas, Tex.
FS-3066	Pontiac	1949	do	4,273	27,008 Diabetes unit, Boston, Mass.
FS-3067	do	1949	do	1,548	29,487 Heart-demonstration unit, Charleston, S. C.
FS-3068	do	1949	do	8,404	39,242 Diabetes unit, Boston, Mass.
FS-3070	do	1949	do	5,495	49,827 Sanitation personnel make inspections and visit States for consultation service.
FS-3088	do	1949	do	7,338	42,470 Consultative services, Boston, Mass.
FS-3089	do	1949	do	4,983	54,201 Dental personnel for consultative purposes, Atlanta, Ga.
FS-3090	do	1949	do	9,243	52,988 Sanitation personnel make inspections and visit States for consultative services, Dallas, Tex.
FS-3223	Ford	1947	do	1,146	22,576 Mental-health consultant concerning mental-health program, College Park, Md.
FS-3593	do	1948	do	524	78,811 Communicable-disease center, Atlanta, Ga.
FS-3613	do	1948	Station wagon	2,485	88,851 Transportation of students, PHS personnel, and training aides, Atlanta, Ga.
FS-3889	Pontiac	1948	Sedan	1,657	37,150 Regional office personnel for inspections, consultation to States, etc., San Francisco, Calif.
FS-3890	Buick	1948	do	6,678	50,597 Sanitation for inspection of vessels and dining cars, Los Angeles, Calif.
FS-3894	do	1948	do	3,897	31,997 Mental health for consultative services, Atlanta, Ga.
FS-3915	Pontiac	1949	do	7,019	46,656 Hospital facility to inspect hospitals being constructed, Washington, D. C.
FS-3916	do	1949	do	2,983	37,563 Sanitation to make inspections and render consultative services, Washington, D. C.
FS-3917	do	1949	do	6,632	51,700 Hospital facility to inspect hospitals being constructed, Washington, D. C.
FS-3918	do	1949	do	6,275	47,425 Do.
FS-3919	do	1949	do	2,875	36,324 Mental health consultants for consultative services, Washington, D. C.
FS-3927	do	1949	do	6,387	37,102 Sanitation for inspection of vessels, Hoboken, N. J.
FS-3930	do	1949	do	5,600	45,400 Sanitation to make inspections and visit States for consultative services, Cleveland, Ohio.
FS-3931	do	1949	do	11,500	33,600 Do.
FS-3984	Ford	1946	do	1,601	51,127 Diabetes unit, Boston, Mass.

Passenger-carrying Motor vehicles on hand as of Mar. 25, 1953 (includes passenger cars, station wagons, ambulances, and buses)—Continued

BUREAU OF STATE SERVICES—Continued

ASSISTANCE TO STATES, GENERAL—Continued

Tag No.	Make	Year	Body style	Mileage driven, July 1 to Dec. 31, 1952	Cumulative mileage as of Dec. 31, 1952	Use and location as of Mar. 25, 1953
FS-4056	Chevrolet	1952	Sedan	2,714	2,714	Field trips in connection with vector control investigations, Denver, Colo.
FS-4057	do	1952	do	4,900	4,900	Field trips in connection with vector control investigations, San Francisco, Calif.
FS-4058	do	1952	do	7,797	7,797	Encephalitis investigations, Greeley, Colo.
FS-4059	do	1952	do	4,141	4,141	Connection with epidemiological activities, Kansas City, Kans.
FS-4067	Pontiac	1951	do	9,915	16,325	Sanitation to inspect community facilities, San Francisco, Calif.
FS-4071	do	1951	do	5,553	16,441	Medical consultants to visit States in region 3, Washington, D. C.
FS-4072	do	1951	do	2,200	10,875	Medical consultants in serving medical programs, Rosebank, Staten Island.
FS-4073	do	1951	do	3,670	12,270	Medical director in consultative services, New York.
FS-4074	do	1951	do	508	6,740	Regional director in consultation regarding public health activities, Boston, Mass.
FS-4082	do	1951	do	4,419	15,620	Regional office consultants visit States in region concerning medical program, Dallas.
FS-4083	do	1951	do	4,453	13,238	Regional office consultants visit States in region concerning medical program, Dallas.
FS-4087	do	1951	do	3,134	6,441	Medical consultants in serving medical programs, Chicago.
FS-4089	do	1951	do	2,800	13,600	Medical consultants for consultation in medical programs, Cleveland.
FS-4090	do	1951	do	8,202	18,809	Sanitation to make inspections and visit States for consultative service, Denver, Colo.
FS-4117	Buick	1951	do	4,180	13,005	Regional director in consultation regarding public health activities, New York.
FS-4122	Pontiac	1951	do	7,009	17,916	Medical director for consultative services, Atlanta, Ga.
FS-4141	Buick	1951	do	1,520	8,622	Regional director in consultation regarding public health activities, San Francisco Calif.
FS-4353	do	1948	do	4,218	15,058	Medical consultants to visit States in region 5, Chicago.
FS-4297	Pontiac	1952	Station wagon	1,070	1,095	Dental health for consultative services, Kansas City, Mo.
FS-4524	Ford	1947	do	3,200	36,000	On loan to Pan American Sanitary Bureau, Washington, D. C.

COMMUNICABLE DISEASE CENTER

CONTROL OF COMMUNICABLE DISEASES

FS-122	Pontiac	1949	Sedan	3,740	26,045	Seattle, Wash.: Transportation of students, PHS personnel and training aids.
FS-142	Buick	1948	do	3,222	39,015	Yonkers, N. Y.: Transportation of students, PHS personnel and training aids.
FS-152	do	1948	do	3,114	21,556	Amherst, Mass.: Transportation of students, PHS personnel and training aids.
FS-170	Pontiac	1948	do	2,323	58,393	Atlanta, Ga.: Transportation of students, PHS personnel and training aids.
FS-186	Ford	1949	do	15,144	50,709	Dallas, Tex.: Used for field trips in connection with vector investigations.
FS-188	do	1949	do	4,855	48,408	Louisville, Ky.: Used in diarrheal disease investigations.
FS-191	do	1949	do	5,005	61,442	Nashville, Tenn.: Used in connection with malaria investigations.
FS-194	do	1949	do	7,000	81,898	Little Rock, Ark.: Used in connection with malaria investigations.
FS-198	do	1949	do	4,053	73,278	Jacksonville, Fla.: Used in connection with malaria investigations.
FS-215	Pontiac	1948	do	7,128	35,797	Mitchell, Nebr.: Used in studies in connection with impure waters.

FS-219	Ford	1949	do	2,698	33,208	Amherst, Mass.: Used for transporting students, PHS personnel and training aids.
FS-220	do	1949	do	4,362	59,237	Little Rock, Ark.: Used in connection with malaria investigations.
FS-225	do	1949	do	4,216	57,496	Mitchell, Nebr.: Used in studies in connection with impure waters.
FS-227	do	1949	do	440	34,580	Little Rock, Ark.: Used in connection with malaria investigations.
FS-228	do	1949	do	8,466	31,365	Santa Fe, N. Mex.: Used for field trips in connection with rodent control.
FS-232	do	1949	do	8,504	69,237	Little Rock, Ark.: Used in training of epidemic intelligence personnel.
FS-233	do	1949	do	2,747	48,772	Montgomery, Ala.: Used in connection with malaria investigations.
FS-243	do	1949	do	12,112	80,352	Macon, Ga.: Used in connection with malaria investigations.
FS-244	do	1949	do	5,538	72,741	Do.
FS-246	do	1949	do	13,267	106,525	Austin, Tex.: Used in connection with typhus investigations.
FS-247	do	1949	do	9,245	77,716	Austin, Tex.: Used in connection with malaria investigations.
FS-253	do	1949	do	6,651	83,900	Austin, Tex.: Used in training of epidemic intelligence personnel.
FS-264	Pontiac	1948	Station wagon	2,999	28,708	Pittsburgh, Pa.: Used in transporting of students, PHS personnel, and training aids.
FS-287	Chevrolet	1942	Sedan	4,415	170,697	Austin, Tex.: Used in connection with typhus investigations.
FS-304	Ford	1950	do	3,163	28,200	Seattle, Wash.: Used for transporting students, PHS personnel, and training aids.
FS-305	Pontiac	1950	Station wagon	10,634	49,890	Montgomery, Ala: Used in connection with virus and rickettsia investigations.
FS-307	Ford	1950	Sedan	14,775	65,729	Austin, Tex.: Used in connection with malaria investigations.
FS-349	Pontiac	1950	do	8,922	47,729	Atlanta, Ga.: Used for field trips in connection with insect vector control.
FS-360	do	1950	do	5,536	44,529	Do.
FS-361	do	1950	do	9,370	72,960	Greeley, Colo.: Used in connection with encephalitis investigations.
FS-386	Ford	1946	do	2,663	63,813	Montgomery, Ala.: Used in connection with virus and rickettsia investigations.
FS-399	do	1949	do	6,265	37,660	Columbus, Ga.: Used for transporting students, PHS personnel, and training aids.
FS-402	International	1944	Bus	1,063	36,764	Atlanta, Ga.: Used for transporting students, PHS personnel, and training aids.
FS-403	Ford	1949	Sedan	3,982	48,014	Newton, Ga.: Used in connection with malaria investigations.
FS-406	do	1949	do	9,075	87,958	Seattle, Wash.: Used in connection with plague investigations.
FS-411	do	1949	do	4,390	38,068	Bakersfield, Calif.: Used in connection with encephalitis investigations.
FS-413	do	1949	do	4,171	33,753	Savannah, Ga.: Used for technical development activities for insect vector control studies.
FS-423	do	1949	do	3,122	25,062	Do.
FS-428	do	1949	do	368	29,596	Do.
FS-536	do	1948	do	2,159	51,107	Yonkers, N. Y.: Used for transporting students, PHS personnel, and training aids.
FS-538	do	1948	do	0	72,203	Raleigh, N. C.: Used in connection with malaria investigations.
FS-688	Plymouth	1942	do	1,314	57,676	Yonkers, N. Y.: Used in transporting students, PHS personnel, and training aids.
FS-750	Buick	1947	do	4,190	44,858	Bloomington, Ill.: Used for transporting students, PHS personnel, and training aid.
FS-865	Ford	1947	do	3,889	52,710	Atlanta, Ga.: Used for general operational functions.
FS-887	Buick	1947	do	5,102	70,304	Montgomery, Ala.: Used in connection with virus and Rickettsia investigations.
FS-916	International	1945	Bus	515	40,872	Chamblee, Ga.: Used for transportation of laboratory training students.
FS-919	Ford	1947	Station wagon	0	53,438	Atlanta, Ga.: Stored pending disposal action.
FS-921	Buick	1947	Sedan	10,580	93,080	Norfolk, Va.: Used in connection with malaria investigations.
FS-922	do	1947	do	4,056	79,346	Bismarck, N. Dak.: Used in studies connected with impure waters.
FS-924	do	1947	do	1,168	73,207	Atlanta, Ga.: Used for field trips in connection with insect-vector control.
FS-925	do	1947	do	3,057	75,937	Do.
FS-926	do	1947	do	2,878	75,861	Hondo, Calif.: Used for "Q" fever investigations.
FS-927	do	1947	do	2,676	70,242	Atlanta, Ga.: Used for field trips in connection with insect-vector control.
FS-930	do	1947	do	5,307	65,027	San Francisco, Calif.: Stored pending disposal.
FS-932	do	1947	do	2,052	73,857	Atlanta, Ga.: Used for field trips on insect-vector control.
FS-933	do	1947	do	5,369	79,614	Salt Lake City, Utah: Stored pending disposal.
FS-935	do	1947	do	1,684	83,556	Atlanta, Ga.: Used for field trips on insect-vector control.
FS-954	do	1947	do	2,921	54,749	Savannah, Ga.: Used for technical-development activities for the insect-vector-control activities.
FS-997	do	1947	do	34	99,513	Atlanta, Ga.: Used for field trips for insect-vector control.
FS-1058	do	1947	do	553	42,375	New Orleans, La.: Used in diarrheal-disease investigations—seasonal operations.

Passenger-carrying Motor vehicles on hand as of Mar. 25, 1953 (includes passenger cars, station wagons, ambulances, and buses)—Continued

COMMUNICABLE DISEASE CENTER—Continued

CONTROL OF COMMUNICABLE DISEASES—Continued

Tag No.	Make	Year	Body style	Mileage driven, July 1 to Dec. 31, 1952	Cumulative mileage as of Dec. 31, 1952	Use and location as of Mar. 25, 1953
FS-1059	Buick	1947	Sedan-passenger	1,996	67,754	Thomasville, Ga.: Uaed in diarrheal-disease investigations.
FS-1066	Ford	1947	Sedan	2,468	66,263	Do.
FS-1168	Buick	1947	do	4,988	44,327	Berkeley, Calif.: Used in studies connected with impure waters.
FS-1169	do	1947	do	802	19,660	San Francisco, Calif.: Used in plague investigations.
FS-1307	Ford	1947	do	1,614	87,082	Atlanta, Ga.: Stored pending disposal action.
FS-1309	do	1947	do	1,212	50,993	Macon, Ga.: Used in connection with typhus investigations.
FS-1311	Buick	1947	do	5	58,900	Salt Lake City, Utah: Stored pending disposal action.
FS-1474	Ford	1947	do	5,187	45,175	Savannah, Ga.: Used for technical-development activities for the insect-vector-control studies.
FS-1691	do	1947	do	2,683	67,565	Jackson, Miss.: Used in connection with typhus investigations.
FS-1707	Pontiac	1948	do	1,479	70,294	Montgomery, Ala.: Used in connection with virus and Rickettsia investigations.
FS-1798	Ford	1947	do	3,702	61,404	Jefferson City, Mo.: Used in connection with malaria investigations.
FS-1813	do	1948	do	6,172	59,165	Raleigh, N. C.: Used in connection with typhus investigations.
FS-1814	do	1947	do	4,147	56,026	Thomasville, Ga.: Used in connection with diarrheal-disease investigations.
FS-1866	do	1947	do	744	83,288	Atlanta, Ga.: Used for transporting students, PHS personnel, and training aids.
FS-1933	International	1945	Bus	2,845	43,379	Savannah, Ga.: Used for technical-development activities for the insect-vector-control studies.
FS-2259	Ford	1947	Sedan	1,843	75,097	Atlanta, Ga.: Used in training of epidemic intelligence personnel.
FS-2260	do	1948	do	5,651	75,303	Nashville, Tenn.: Used in connection with malaria investigations.
FS-2261	do	1948	do	3,288	55,451	Atlanta, Ga.: Used in training of epidemic intelligence personnel.
FS-2340	do	1950	do	7,753	42,593	Columbia, S. C.: Used in training of epidemic intelligence personnel.
FS-2357	do	1950	do	6,389	45,406	Jackson, Miss.: Used in connection with malaria investigations.
FS-2360	do	1950	do	5,595	43,857	Phoenix, Ariz.: Used in connection with diarrheal-disease investigations.
FS-2361	do	1950	do	1,806	18,224	Atlanta, Ga.: Used by executive personnel in connection with communicable-disease-center clinic.
FS-2403	Plymouth	1942	do	1,024	10,542	Savannah, Ga.: Used for technical-development activities for the insect-vector-control studies.
FS-2419	Ford	1950	do	14,848	70,330	Santa Fe, N. Mex.: Used in diarrheal and dysentery investigations.
FS-2423	Chevrolet	1942	do	2,105	39,951	Savannah, Ga.: Used for technical development activities for the insect vector control studies.
FS-2431	Ford	1950	do	7,171	31,500	Cleveland, Ohio: Used for consultation in communicable disease center programs.
FS-2472	do	1950	do	8,320	45,075	Jackson, Miss.: Used in connection with malaria investigations.
FS-2512	Buick	1948	do	1,659	46,218	Mitchell, Nebr.: Used in studies in connection with impure waters.
FS-2845	Ford	1948	do	5,654	116,952	Corpus Christi, Tex.: Used in connection with leprosy control.
FS-2846	do	1948	do	1,003	42,828	Phoenix, Ariz.: Used in connection with polio studies.
FS-2847	do	1948	do	1,207	51,472	Salt Lake City, Utah: Used in training for epidemic intelligence investigations.
FS-2857	do	1948	do	5,173	64,678	Jacksonville, Fla.: Used in connection with malaria investigations.
FS-2858	do	1948	do	1,531	51,361	Jacksonville, Fla.: Used in connection with typhus control.

FS-2847	do	1948	do	5,173	63,678	Jacksonville, Fla.: Used in connection with typhus control.
FS-2857	do	1948	do	1,531	51,361	Jacksonville, Fla.: Used in connection with typhus control.
FS-2858	do					

FS-2916	do	1949	do	3,915	25,611	Cleveland, Miss.: Used for toxicology studies under insect vector control.
FS-2917	do	1949	do	5,450	48,057	Montgomery, Ala.: Used in training of epidemic intelligence personnel.
FS-2918	do	1949	do	3,570	33,261	Denver, Colo.: Used for transporting students, PHS personnel and training aids.
FS-2919	do	1949	do	10,901	75,317	Austin, Tex.: Used in diarrheal disease investigations.
FS-2920	do	1949	do	700	31,500	Boston, Mass.: Used in connection with river basin studies.
FS-2921	do	1949	do	6,336	55,650	Phoenix, Ariz.: Used in connection with polio studies.
FS-2922	do	1949	do	4,921	35,139	Charleston, W. Va.: Used in connection with polio studies.
FS-2923	do	1949	Sedan-passenger	3,917	33,823	Thomasville, Ga.: Used in connection with diarrheal disease investigations.
FS-2924	do	1949	do	2,572	28,790	Do.
FS-2925	do	1949	Sedan	14,651	58,506	Jackson, Miss.: Used for epidemic intelligence investigations.
FS-2999	do	1949	do	7,699	75,189	Hamilton, Mont.: Used for epidemic intelligence investigations.
FS-3000	do	1949	do	4,706	89,654	Monroe, La.: Used in training of epidemiology intelligence personnel.
FS-3001	do	1949	do	2,726	40,119	Jackson, Miss.: Used in connection with malaria investigations.
FS-3002	do	1949	do	3,097	49,851	Thomasville, Ga.: Used in connection with diarrheal disease investigations.
FS-3006	do	1949	do	5,081	36,588	Columbia, S. C.: Used in connection with malaria investigations.
FS-3007	do	1949	do	8,729	40,485	New York, N. Y.: Used in field trips for insect vector inspection.
FS-3019	do	1949	do	5,545	114,012	Oklahoma City, Okla.: Used in connection with malaria investigations.
FS-3032	do	1949	do	3,155	65,784	Nashville, Tenn.: Used in connection with typhus investigations.
FS-3056	do	1949	do	2,303	20,316	Phoenix, Ariz.: Used in connection with polio studies.
FS-3057	do	1949	do	11,424	110,914	Austin, Tex.: Used in training of epidemic intelligence personnel.
FS-3058	do	1949	do	10,789	66,069	Austin, Tex.: Used in connection with typhus investigations.
FS-3192	do	1949	do	3	54,769	Atlanta, Ga.: Stored, pending disposal action.
FS-3208	do	1947	do	974	12,935	Santa Fe, N. Mex.: Used in plague investigations.
FS-3211	do	1950	do	8,408	40,630	Louisville, Ky.: Used in connection with malaria investigations.
FS-3212	do	1950	do	4,117	35,328	Little Rock, Ark.: Used in connection with river basin studies.
FS-3213	do	1950	do	3,426	13,792	Cincinnati, Ohio: Used for regular interbuilding messenger service between 3 locations in Cincinnati.
FS-3214	do	1950	do	2,241	39,507	Kansas City, Kans.: Used in connection with histoplasmosis investigations.
FS-3215	do	1950	do	1,462	32,879	Kansas City, Mo.: Used in connection with river basin studies.
FS-3216	do	1950	do	8,042	55,842	Mitchell, Nebr.: Used in connection with encephalitis investigations.
FS-3224	do	1947	do	0	27,485	Atlanta, Ga.: Stored, pending disposal action.
FS-3226	do	1947	do	9,612	45,027	Austin, Tex.: Transportation of students, PHS personnel and training aids.
FS-3228	do	1950	do	4,034	47,473	Austin, Tex.: Used in connection with malaria investigations.
FS-3229	do	1950	do	913	11,953	Little Rock, Ark.: Used in connection with polio studies.
FS-3230	do	1950	do	954	8,152	Phoenix, Ariz.: Used in connection with polio studies.
FS-3231	do	1950	do	10,893	48,346	Do.
FS-3232	do	1950	do	4,629	21,139	Jackson, Miss.: Used in training of epidemiology intelligence personnel.
FS-3233	do	1950	do	3,224	19,275	Charleston, W. Va.: Used in connection with polio studies.
FS-3301	Pontiac	1950	do	4,760	47,718	Do.
FS-3319	Ford	1950	Station wagon	3,033	30,929	Atlanta, Ga.: Field trips for insect-vector-control.
FS-3327	Pontiac	1950	Sedan	10,199	51,735	Atlanta, Ga.: Used for general occupational functions.
FS-3388	do	1951	do	7,639	30,246	Atlanta, Ga.: Used in connection with malaria investigations.
FS-3389	do	1951	do	2,967	11,653	Little Rock, Ark.: Used in connection with encephalitis investigations.
FS-3390	do	1951	do	11,156	30,571	Greeley, Colo.: Used in connection with malaria investigations.
FS-3391	do	1951	do	6,070	24,048	Davis, Colo.: Used for "Q" fever investigations.
FS-3392	do	1951	do	12,063	35,629	Berkeley, Calif.: Used in connection with malaria investigations.
FS-3393	do	1951	do	5,888	21,338	Portland, Oreg.: Used in connection with river-basin studies.
FS-3394	do	1951	do	12,855	41,653	Columbia, S. C.: Used in connection with malaria investigations.
FS-3395	do	1951	do	11,091	39,748	Washington, D. C.: Used in field trips for vector investigations.
FS-3396	do	1951	do	2,534	15,900	Atlanta, Ga.: Used for field trips for insect-vector control.
FS-3397	do	1951	do	5,383	13,128	Do.
FS-3398	do	1951	do	3,277	19,628	Do.
						Do.

Passenger-carrying Motor vehicles on hand as of Mar. 25, 1953 (includes passenger cars, station wagons, ambulances, and buses)—Continued

COMMUNICABLE DISEASE CENTER—Continued

CONTROL OF COMMUNICABLE DISEASES—Continued

Tag No.	Make	Year	Body style	Mileage driven, July 1 to Dec. 31, 1952	Cumulative mileage as of Dec. 31, 1952	Use and location as of Mar. 25, 1953
FS-3399	Pontiac	1951	Sedan	2,882	19,142	Harrisburg, Pa.: Used for transporting students, PHS personnel, and training aids.
FS-3400	do	1951	do	4,509	27,878	Topeka, Kans.: Used for transporting students, PHS personnel, and training aids.
FS-3401	do	1951	do	3,877	17,739	Chamblee, Ga.: Used in collection of specimens and trips by professional staff to Emory University and headquarters office.
FS-3420	do	1950	do	1,372	10,496	New Orleans, La.: Used for diarrheal-disease investigations (seasonal operations).
FS-3421	do	1951	do	6,788	22,932	Thomasville, Ga.: Used in connection with diarrheal-disease investigations.
FS-3422	do	1951	do	4,887	13,144	Charleston, W. Va.: Used in connection with polio studies.
FS-3423	do	1951	do	1,900	6,555	Phoenix, Ariz.: Used in connection with polio studies.
FS-3424	do	1951	do	6,584	23,764	Wenatchee, Wash.: Used for toxicology studies under insect-vector control.
FS-3425	do	1951	do	3,241	12,513	Savannah, Ga.: Used for technical-development activities for the insect-vector studies.
FS-3585	Ford	1948	do	10,032	69,714	Berkeley, Calif.: Used in connection with malaria investigations.
FS-3586	do	1948	do	0	54,172	Columbia, S. C.: Used in connection with malaria investigations.
FS-3587	do	1948	do	1,655	49,833	Atlanta, Ga.: Used in training of epidemiology intelligence personnel.
FS-3588	do	1948	do	405	56,755	Atlanta, Ga.: Used in seasonal field operations.
FS-3589	do	1948	do	2,104	54,678	Charleston, W. Va.: Used in connection with polio studies.
FS-3590	do	1948	do	10,348	78,128	New Orleans, La.: Used in connection with typhus investigaitons.
FS-3591	do	1948	do	1,780	71,610	Little Rock, Ark.: Stored—awaiting disposal action.
FS-3592	do	1948	do	619	64,334	Atlanta, Ga.: Used in seasonal field operations.
FS-3594	do	1948	do	4,154	48,556	San Juan, P. R.: Used in connection with malaria investigations.
FS-3614	do	1948	Station wagon	4,063	45,313	Savannah, Ga.: Used for technical-development activities for the insect-vector studies.
FS-3688	Chevrolet	1948	Sedan	6,063	60,489	Little Rock, Ark.: Used in connection with typhus investigations.
FS-3690	do	1948	do	6,225	83,225	Nashville, Tenn.: Used in connection with malaria investigations.
FS-3786	Pontiac	1948	do	9,884	68,545	Nashville, Tenn.: Used in training of epidemiology intelligence personnel.
FS-4036	Chevrolet	1952	do	10,239	11,578	Atlanta, Ga.: Used for field trips for insect vector control.
FS-4037	do	1952	do	10,631	12,125	Do.
FS-4038	do	1952	do	9,469	10,910	Do.
FS-4039	do	1952	do	8,925	11,004	Do.
FS-4040	do	1952	do	9,511	11,405	Do.
FS-4041	do	1952	do	10,465	10,890	Atlanta, Ga.: Used by administrative personnel on field trips.
FS-4042	do	1952	do	5,620	12,116	Phoenix, Arix.: Used in studies connected with impure waters.
FS-4043	do	1952	do	4,851	5,793	Kansas City, Mo.: Used for field trips connected with vector investigations.
FS-4044	do	1952	do	7,787	11,490	Kansas City, Mo.: Used for general epidemiological activities.
FS-4045	do	1952	do	6,845	8,543	Do.
FS-4053	Ford	1947	do	3,071	53,528	Chamblee, Ga.: Used for collection of specimens and trips by professional staff to University and Headquarters office.
FS-4054	do	1947	do	4,237	54,135	Do.
FS-4189	Pontiac	1953	Station wagon	0	0	Montgomery, Ala.: Used for transporting students, PHS personnel and training aids.
FS-4204	Chevrolet	1953	Sedan	0	0	Puerto Rico: Used for field trips on insect vector control.

				0	0	Montgomery, Ala.: Used for transporting students, PHS personnel and training aids.
				0	0	Puerto Rico: Used for field trips on insect vector control.
FS-4205	do	1953	do	0	0	Atlanta, Ga.: Used for transportation of students, PHS personnel and training aids.
FS-4206	do	1953	do	0	0	Newton, Ga.: Used in connection with malaria investigations.
FS-4207	do	1953	do	0	0	Savannah, Ga.: Used for technical development activities for insect vector control activities.
FS-4208	do	1953	do	0	0	Do.
FS-4209	do	1953	do	0	0	Do.
FS-4210	do	1953	do	0	0	Do.
FS-4211	do	1953	do	0	0	Boston, Mass.: Used for field trips in connection with vector investigations.
FS-4212	do	1953	do	0	0	New York, N. Y.: Used for field trips in connection with vector investigations.
FS-4213	do	1953	do	0	0	Cleveland, Ohio: Used for field trips in connection with vector investigations.
FS-4214	do	1953	do	0	0	Chicago, Ill.: Used for field trips in connection with vector investigations.
FS-4215	do	1953	do	0	0	Dallas, Tex.: Used for field trips in connection with vector investigations.
FS-4216	do	1953	do	0	0	Kansas City, Mo.: Used for field trips in connection with vector investigations.
FS-4217	do	1953	do	0	0	San Francisco, Calif.: Used for field trips in connection with vector investigations.
FS-4218	do	1953	do	0	0	San Francisco, Calif.: Used in connection with plague investigations.
FS-4219	do	1953	do	0	0	Mitchell, Nebr.: Used in connection with insect vector control and water projects.
FS-4220	do	1953	do	0	0	Salt Lake City, Utah: Used in connection with insect vector control and water projects.
FS-4221	do	1953	do	0	0	Do.
FS-4222	Ford	1953	do	0	0	Amherst, Mass.: Used in transportation of students, PHS personnel, and training aids.
FS-4190	Chevrolet	1953	do	0	0	Atlanta, Ga.: For use in field investigations in veterinary public health and epidemiology.
FS-4191	do	1953	do	0	0	Do.
FS-4192	do	1953	do	0	0	Do.
FS-4193	do	1953	do	0	0	Do.
FS-4194	do	1953	do	0	0	Do.
FS-4195	do	1953	do	0	0	Do.
FS-4196	do	1953	do	0	0	Do.
FS-4197	do	1953	do	0	0	Do.
FS-4198	do	1953	do	0	0	Do.
FS-4199	do	1953	do	0	0	Do.
FS-4200	do	1953	do	0	0	Do.
FS-4201	do	1953	do	0	0	Do.
FS-4202	do	1953	do	0	0	Do.
FS-4203	do	1953	do	0	0	Thomasville, Ga.: Used in diarrheal disease investigations.

BUREAU OF STATE SERVICES

Engineering, Sanitation, and Industrial Hygiene, PHS

FS-222	Chevrolet	1948	Sedan	2,286	27,629	Mobile, Ala.: To make inspections of American flag vessels docking on Gulf coast.
FS-331	Ford	1946	do	3,376	63,669	Detroit, Mich.: Field studies of occupational health problems.
FS-582	Pontiac	1949	do	2,289	21,127	San Francisco, Calif.: To make field investigations in connection with pollution problems.
FS-604	do	1949	do	1,247	15,301	Cincinnati, Ohio: Physics and chemistry section, sewage and waste sampling studies.
FS-615	do	1949	do	7,634	17,916	Cincinnati, Ohio: Milk and food research, sampling surveys.
FS-624	do	1949	do	7,716	48,087	Cincinnati, Ohio: Field surveys and general station use.
FS-627	do	1949	do	5,152	51,040	Richland, Wash.: Field work on Columbia River water studies.
FS-632	do	1949	do	4,538	46,219	Cincinnati, Ohio: Field surveys.

Passenger-carrying motor vehicles on hand as of Mar. 25, 1953 (includes passenger cars, station wagons, ambulances, and buses)—Continued

BUREAU OF STATE SERVICES—Continued

ENGINEERING, SANITATION, AND INDUSTRIAL HYGIENE, PHS—Continued

Tag No.	Make	Year	Body style	Mileage driven, July 1 to Dec. 31, 1952	Cumulative mileage as of Dec. 31, 1952	Use and location as of Mar. 25, 1953
FS-653	Pontiac	1949	Sedan	747	14,408	Chicago, Ill.: River basin surveys in furtherance of water pollution control activities.
FS-661	do	1949	do	11,385	41,638	Do.
FS-678	do	1948	do	3,955	48,799	New York City: Used by sanitation personnel to make surveys, inspections and consultative services.
FS-733	do	1949	do	5,248	22,946	Hoboken, N. J.: Used by sanitation personnel to make surveys, inspections and consultative services.
FS-797	do	1949	do	14,315	60,551	Kansas City, Mo.: Used by engineering personnel to make surveys, inspections and visit States for consultative services.
FS-799	do	1949	do	6,443	27,183	Boston, Mass.: To make field investigations in connection with water pollution control activities.
FS-813	do	1949	do	8,469	57,314	Tulsa, Okla.: To make river basin surveys in connection with water pollution activities.
FS-877	do	1949	do	8,282	47,294	Aiken, S. C.: Used in community facilities work arising from Atomic Energy problems.
FS-879	do	1950	do	3,010	35,672	Atlanta, Ga.: To make river basin surveys in connection with water pollution activities.
FS-894	Ford	1947	do	492	44,385	Cincinnati, Ohio: Local sampling surveys.
FS-1025	do	1949	do	2,314	47,360	Portland, Oreg.: To make river basin surveys in connection with water pollution activities.
FS-1051	Pontiac	1950	do	11,630	65,080	Boston, Mass.: Used by engineering personnel to make inspections and visit States concerning water pollution activities.
FS-1350	do	1950	do	10,735	40,431	Dallas, Tex.: Used by sanitation personnel to make inspections and visit States for consultative service.
FS-1525	do	1950	do	3,775	28,900	Cleveland, Ohio: Used by regional office consultants to visit States in region for consultative services.
FS-2187	do	1950	Station wagon	3,561	31,665	Cincinnati, Ohio: Field surveys.
FS-2231	do	1948	Sedan	5,738	61,328	Boston, Mass.: Used by regional office consultants to visit States in region for consultative services.
FS-2417	Plymouth	1942	do	296	54,653	Cincinnati, Ohio: Local sampling surveys.
FS-2513	Ford	1946	do	1,992	85,651	Salt Lake City, Utah: Conducting of occupational health field problems.
FS-2543	do	1948	do	2,239	21,364	Woods Hole, Mass.: Field work on shellfish sanitation investigations.
FS-3276	Pontiac	1950	do	5,690	38,000	Portland, Oreg.: To make river basin surveys in connection with water pollution activities.
FS-3479	Buick	1947	do	4,901	62,182	Salt Lake City, Utah: Conducting of occupational health field studies.
FS-3480	do	1947	do	7,803	49,291	Cincinnati, Ohio: Conducting of occupational health field studies.
FS-3859	Ford	1949	do	1,929	19,800	San Francisco, Calif.: To make vessel and dining car inspections.

FS-3872	do	1949	do	15,756	80,438	Kansas City, Mo.: Used by engineering personnel to make surveys, inspections and visit States for consultative services.
FS-3908	do	1949	do	5,224	31,424	Tullytown, Pa.: For use in sanitary engineering work for HHFA.
FS-3974	Pontiac	1951	Station wagon	3,803	16,163	San Francisco, Calif.: To make field investigations in connection with pollution problems.
FS-3982	Buick	1950	Sedan	2,093	15,900	Little Rock, Ark.: To make river-basin surveys in connection with water-pollution activities.
FS-3993	Pontiac	1951	Station wagon	3,359	21,206	Albuquerque, N. Mex.: To make river-basin surveys in connection with water-pollution activities.
FS-3994	do	1951	Sedan	5,934	19,140	Cincinnati, Ohio: To perform official travel in connection with field activities of water-pollution program.
FS-3995	do	1951	do	5,512	21,450	Do.
FS-3996	do	1951	do	654	10,297	Cincinnati, Ohio: General station use.
FS-4000	do	1951	Station wagon	1,618	9,062	Atlanta, Ga.: To make river-basin surveys in connection with water-pollution activities.
FS-4001	do	1951	Sedan	7,553	20,089	Boston, Mass.: Used by regional-office personnel to visit States in region for consultative services.
FS-4064	do	1951	Station wagon	8,362	14,020	Little Rock, Ark.: To make river-basin surveys in connection with water-pollution activities.
FS-4066	do	1951	Sedan	9,921	31,670	Richland, Wash.: Field work on Columbia River water studies.
FS-4069	do	1951	do	5,022	16,800	Portland, Oreg.: To make river-basin surveys in connection with water-pollution activities.
FS-4075	do	1951	do	2,156	11,564	Washington, D. C.: Used by personnel for consultation and technical assistance on problems of sanitary engineering.
FS-4076	do	1951	do	5,842	16,048	Washington, D. C.: Used by personnel for consultation and technical assistance on milk and food problems.
FS-4080	do	1951	do	7,678	20,960	Kansas City, Mo.: Used by engineering personnel to make surveys, inspections, and consultative services.
FS-4088	do	1951	do	3,554	17,990	Chicago, Ill.: Used by engineering personnel to make surveys, inspections, and consultative services.
FS-4102	do	1951	do	6,320	17,954	Boston, Mass.: Used by regional-office personnel to visit States in region in connection with water-pollution activities.
FS-4123	do	1951	do	8,672	18,180	Kansas City, Mo.: Used by engineering personnel to make inspections, surveys, and consultative services.
FS-4124	do	1951	do	6,581	20,800	Chicago, Ill.: Used by engineering personnel to make inspections and visit States for consultative service.
FS-4125	do	1951	do	6,925	16,337	Kansas City, Mo.: Used by engineering personnel to make inspections and visit States for consultative service.
FS-4163	do	1951	do	6,102	10,800	Dallas, Tex.: To make river-basin surveys in connection with water-pollution activities.
FS-4350	Ford	1952	do	2,148	2,148	Cincinnati, Ohio: Conducting of occupational-health field studies.
FS-4127	Plymouth	1951	Stationwagon	(1)	(1)	Jacksonville, Fla.: Environmental health studies.
FS-4128	do	1951	do	(1)	(1)	Augusta, Ga.: Environmental health studies.

[1] Mileage figures not available.

Passenger-carrying motor vehicles on hand as of Mar. 25, 1953 (includes passenger cars, station wagons, ambulances, and buses)—Continued

BUREAU OF STATE SERVICES—Continued

DISEASE AND SANITATION INVESTIGATIONS AND CONTROL TERRITORY OF ALASKA PUBLIC HEALTH SERVICE

Tag No.	Make	Year	Body style	Mileage driven, July 1 to Dec. 31, 1952	Cumulative mileage as of Dec. 31, 1952	Use and location as of Mar. 25, 1953
FS-250	Ford	1949	Sedan	3,398	24,091	Anchorage, Alaska: Used by professional and other personnel in health and sanitation investigations
FS-3277	Willys	1950	Station wagon	5,415	28,502	Do.
FS-3906	Ford	1948	Sedan	1,392	37,447	Do.
FS-4295	Chevrolet	1952	do	5,570	5,570	Do.

BUREAU OF MEDICAL SERVICES

SALARIES AND EXPENSES, HOSPITAL CONSTRUCTION SERVICES, PUBLIC HEALTH SERVICE

FS-371	Pontiac	1948	Sedan	5,894	38,919	San Francisco, Calif.: Used to make inspections of hospitals being constructed.
FS-785	Buick	1947	do	0	68,641	Kansas City, Mo.: Used to make inspections of hospitals being constructed.
FS-1479	Pontiac	1948	do	3,437	44,044	Do.
FS-1559	do	1948	do	4,854	45,911	Washington, D. C.: Used to make inspections of hospitals being constructed.
FS-2503	do	1948	do	1,389	66,567	Atlanta, Ga.: Used to make inspections of hospitals being constructed.
FS-3402	do	1950	do	8,168	33,374	Washington, D. C.: Used to make inspections of hospitals being constructed.
FS-3405	do	1950	do	5,593	43,774	Dallas, Tex.: Used to make inspections of hospitals being constructed.
FS-3406	do	1950	do	2,900	14,714	Chicago, Ill.: Used to make inspections of hospitals being constructed.
FS-3852	do	1948	do	3,537	43,580	Denver, Colo.: Used to make inspections of hospitals being constructed.
FS-3881	Ford	1949	do	1,335	23,125	Washington, D. C.: Used to make inspections of hospitals being constructed.
FS-3882	do	1949	do	1,243	25,843	New York, N. Y.: Used to make inspections of hospitals being constructed.
FS-3913	Pontiac	1949	do	9,441	28,020	Atlanta, Ga.: Used to make inspections of hospitals being constructed.
FS-3914	do	1949	do	1,850	34,450	Cleveland, Ohio: Used to make inspections of hospitals being constructed.
FS-4126	do	1951	do	1,679	3,914	Chicago, Ill.: Used to make inspections of hospitals being constructed.
FS-4143	do	1951	do	8,546	14,409	Dallas, Tex.: Used to make inspections of hospitals being constructed.
FS-4149	do	1951	do	10,920	20,674	Atlanta, Ga.: Used to make inspections of hospitals being constructed.
FS-4156	do	1951	do	2,954	4,413	Denver, Colo.: Used to make inspections of hospitals being constructed.
FS-4290	do	1952	do	184	184	San Francisco, Calif.: Used to make inspections of hospitals being constructed.

GENERAL STATEMENT.—*Usage of sedans and station wagons:* Transportation of patients and employees on official business incident to operation of the facility, for example: Pickup of emergency purchases, procurement of subsistence, transportation of laboratory specimens, and attendance of personnel at clinics and meetings, etc. *Usage of ambulances:* Transport patients from clinics and outpatient offices to hospitals and for use in emergency cases]

Tag No.	Make	Year	Body style	Mileage driven, July 1 to Dec. 31, 1952	Cumulative mileage as of Dec. 31, 1952	Use and location as of Mar. 25, 1953
824	Buick	1938	Ambulance	689	28, 406	Baltimore, Md.
825	Packard	1948	do	1, 777	17, 866	Do.
3868	Ford	1949	Sedan	2, 552	30, 289	Do.
4240	Pontiac	1951	do	547	2, 874	Do.
4255	Buick	1947	do	3, 530	47, 286	Do.
4256	do	1947	do	3, 613	40, 666	Do.
1830	Pontiac	1947	Station wagon	839	12, 674	Boston, Mass.
3284	Buick	1947	Sedan	2, 810	13, 788	Do.
3289	Ford	1948	Station wagon	4, 519	41, 015	Do.
4298	Pontiac	1952	Ambulance	1, 806	2, 687	Do.
128	Packard	1939	do	706	79, 268	Carville, La.
328	Cadillac	1948	do	5, 484	32, 000	Do.
750	International	1947	Bus	1, 919	24, 863	Carville, La.: Used to transport children of families with quarters on isolated station to and from nearest school 6 miles distant (Public Law 124, 79th Cong.).
757	Buick	1947	Sedan	1, 135	46, 975	Carville, La.
760	Pontiac	1948	do	3, 796	53, 206	Do.
2539	Packard	1940	Ambulance	9	58, 908	Do.
3943	Ford	1949	Sedan	4, 552	49, 179	Do.
4065	De Soto	1951	Station wagon	22, 415	78, 741	Do.
4119	Ford	1951	do	7, 245	25, 093	Do.
181	La Salle	1939	Ambulance	2, 096	28, 680	Chicago, Ill.
1475	Buick	1947	Sedan	1, 235	19, 670	Do.
2899	Pontiac	1949	do	3, 802	40, 730	Do.
771	Packard	1940	Ambulance	468	14, 042	Cleveland, Ohio: Awaiting disposition.
1053	Pontiac	1947	Station wagon	3, 076	36, 990	Cleveland, Ohio.
4135	do	1951	Sedan	1, 760	7, 104	Do.
826	Cadillac	1948	Ambulance	5, 545	25, 896	Detroit, Mich.
838	Pontiac	1948	Sedan	3, 857	47, 401	Do.
4139	do	1951	do	4, 230	12, 252	Do.
130	do	1947	Station wagon	972	19, 813	Fort Stanton, N. Mex.
3101	do	1949	Sedan	2, 840	23, 241	Do.
427	Cadillac	1939	Ambulance	634	19, 309	Fort Worth, Tex.
1670	Chevrolet	1950	Sedan	5, 492	48, 913	Do.
2545	Buick	1947	do	4, 747	40, 589	Do.
3950	Pontiac	1948	Station wagon	4, 782	50, 601	Do.

Passenger-carrying motor vehicles on hand as of Mar. 25, 1953 (includes passenger cars, station wagons, ambulances, and buses)—Continued

DIVISION OF HOSPITALS—Continued

HOSPITALS AND MEDICAL CARE, PHS, 1953—Continued

Tag No.	Make	Year	Body style	Mileage driven, July 1 to Dec. 31, 1952	Cumulative mileage as of Dec. 31, 1952	Use and location as of Mar. 25, 1953
4166	Pontiac	1951	Station wagon	8,625	20,114	Fort worth, Tex.
4172	do	1951	Sedan	2,144	6,200	Do.
4280	Ford	1952	do	7,369	7,369	Do.
4281	do	1952	do	7,598	7,598	Do.
177	Pontiac	1949	do	6,619	21,780	Galveston, Tex.
2458	Ford	1942	do	6,893	46,567	Do.
107	do	1948	Station wagon	5,557	37,607	Lexington, Ky.
481	Plymouth	1942	Sedan	4,817	105,056	Do.
3251	Ford	1947	do	6,437	74,600	Do.
3411	Henney-Packard	1948	Ambulance	1,105	9,495	Do.
3944	General Motors	1949	Bus	4,554	46,667	Lexington, Ky.: Used for the transportation of school children, in accordance with Public Law 124, 79th Cong.; large groups of patient transfers to other Government installations; and other movements of large groups of patients.
4170	Pontiac	1951	Sedan	3,983	8,475	Lexington, Ky.
4267	Chevrolet	1952	do	5,020	6,827	Do.
144	Pontiac	1947	Station wagon	1,943	29,319	Manhattan Beach, N. Y.
182	Henney-Packard	1940	Ambulance	1,076	27,290	Do.
1959	Ford	1945	do	1,257	37,825	Do.
2060	do	1947	Sedan	1,717	30,709	Do.
2113	do	1949	do	1,360	15,703	Do.
100	Pontiac	1949	do	3,974	22,139	Memphis, Tenn.
2496	do	1947	do	2,624	39,473	Do.
166	do	1949	do	4,464	22,076	New Orleans, La.
168	do	1949	Station wagon	5,021	30,423	Do.
2537	Packard	1940	Ambulance	718	40,135	Do.
2542	Pontiac	1947	Sedan	2,805	36,184	Do.
839	Ford	1948	Station wagon	2,353	35,340	Norfolk, Va.
2017	Cadillac	1948	Ambulance	848	101,760	Do.
4130	Pontiac	1951	Sedan	3,482	8,146	Do.
1258	Packard	1941	Ambulance	689	48,199	San Francisco, Calif.
3933	do	1948	do	1,024	13,524	Do.
3934	Pontiac	1947	Station wagon	1,577	30,372	Do.
3935	Buick	1947	Sedan	1,343	24,073	Do.
4282	Ford	1952	do	2,464	2,464	Do.
105	Buick	1947	do	679	8,762	Savannah, Ga.

129	Pontiac	1947	Station wagon	1,820	27,038	Seattle, Wash.
3912	Cadillac	1948	Ambulance	1,546	13,288	Do.
4171	Pontiac	1951	Sedan	3,801	9,853	Do.
111	Packard	1942	Ambulance	951	22,364	Staten Island, N. Y.
121	Pontiac	1949	Station wagon	3,888	22,045	Do.
214	do	1948	Sedan	3,211	21,886	Do.
3899	do	1947	do	1,926	25,503	Do.
4085	Ford	1950	Station wagon	926	5,310	Do.

OUTPATIENT CLINICS

2502	Buick	1947	Sedan	7,060	21,805	Buffalo, N. Y.
259	Pontiac	1948	do	370	12,870	Houston, Tex.
104	Packard	1941	Ambulance	951	62,425	Kirkwood, Mo. (awaiting disposition).
858	Ford	1947	Station wagon	2,790	64,979	Kirkwood, Mo.
3102	Pontiac	1949	Sedan	4,536	20,840	Do.
846	Buick	1947	do	6,879	73,189	Los Angeles, Calif.
4164	Pontiac	1951	Station wagon	1,766	5,955	Do.
4270	Ford	1952	Sedan	1,217	1,225	Mobile, Ala.
121	Pontiac	1949	do	1,032	8,947	New York, N. Y.
736	Packard	1948	Ambulance	3,518	37,135	Do.
739	do	1942	do	1,568	77,089	Do.
385	do	1939	do	212	90,937	Do.
3103	Cadillac	1949	do	4,862	31,673	Do.
4278	Ford	1952	Sedan	52	3,070	Philadelphia, Pa.
3104	Pontiac	1949	do	1,209	14,201	Pittsburgh, Pa.
2478	Buick	1947	do	1,806	29,886	Port Arthur, Tex.
109	Pontiac	1947	Station wagon	1,847	24,383	Portland, Maine.
238	do	1948	Sedan	3,585	33,689	San Diego, Calif.
1587	do	1948	do	4,014	35,167	Washington, D. C.
3746	do	1947	do	4,808	35,005	Do.
3984	do	1949	do	4,512	33,201	Do.
600	Buick	1947	do	3,903	39,187	San Juan, P. R.
3986	Pontiac	1947	do	2,906	35,743	Do.
4251	do	1951	Station wagon	2,149	3,848	Do.
2400	Buick	1947	Sedan	2,272	24,187	Bureau of Medical Services: Transportation of Division and Bureau personnel on official business in the Washington area.

Passenger-carrying motor vehicles on hand as of Mar. 25, 1953 (includes passenger cars, station wagons, ambulances, and buses)—Continued

DIVISION OF FOREIGN QUARANTINE

FOREIGN QUARANTINE SERVICE, PUBLIC HEALTH SERVICE, 1953

[GENERAL STATEMENT: These sedans and station wagons are for use of officers and employees at the various foreign quarantine stations in connection with the inspection and fumigation of ships and airplanes arriving from foreign ports.]

Tag No.	Make	Year	Body style	Mileage driven, July 1 to Dec. 31, 1952	Cumulative mileage as of Dec. 31, 1952	Use and location as of Mar. 25, 1953
460	Plymouth	1942	Sedan	4,205	68,304	Baltimore, Md.
1636	Chevrolet	1950	do	1,757	12,692	Do.
1706	Pontiac	1948	Station wagon	2,191	29,635	Do.
3978	Buick	1950	Sedan	2,506	9,921	Do.
306	do	1940	do	2,469	65,620	Boston, Mass.
330	do	1940	do	1,861	75,760	Do.
332	do	1947	do	4,761	43,396	Do.
1894	Kaiser	1950	do	2,567	11,576	Do.
778	Buick	1947	do	2,565	36,553	Brownsville, Tex.
784	Plymouth	1946	do	2,587	55,185	Do.
3856	Ford	1949	do	3,477	37,798	Charleston, S. C.
457	Pontiac	1949	do	12,051	40,380	El Paso, Tex.
763	Dodge	1947	do	1,904	39,498	Do.
844	Buick	1947	do	2,066	33,670	El Paso, Tex.: Assigned to Laredo, Tex.
1997	Kaiser	1950	do	2,557	23,764	El Paso, Tex.
3071	Buick	1948	do	10,504	38,741	El Paso, Tex.: Assigned to Farm Placement.
3981	do	1950	do	4,417	18,464	El Paso, Tex.: Assigned to Nogales, Ariz.
315	Chevrolet	1940	Station wagon	2,137	35,308	Fort Monroe, Va.
2416	Plymouth	1942	Sedan	3,040	44,867	Do.
252	Pontiac	1948	Station wagon	None	34,144	Galveston, Tex.: Awaiting disposition.
1973	Kaiser	1950	Sedan	1,393	16,922	Galveston, Tex.
3073	Pontiac	1949	do	2,291	34,291	Do.
4012	Buick	1950	do	5,392	18,950	Do.
4276	Ford	1952	do	9,093	9,107	Do.
1249	Plymouth	1942	do	1,900	113,000	Jacksonville, Fla.
3873	Ford	1949	do	2,715	40,549	Do.
4086	Pontiac	1951	do	4,251	14,872	Do.
357	Pontiac	1941	Sedan	1,807	72,459	Miami Beach, Fla., awaiting disposition.
860	Plymouth	1947	do	4,500	32,023	Miami Beach, Fla.
861	Willys	1948	Station wagon	2,765	23,572	Do.
1704	Plymouth	1942	Sedan	5,481	71,895	Miami Beach, Fla. (West Palm Beach).
2191	Kaiser	1950	do	1,351	12,659	Miami Beach, Fla.
3986	Buick	1950	do	2,204	11,846	Do.
998	Ford	1950	do	2,376	16,464	Mobile, Ala.
1252	Plymouth	1947	do	1,816	55,869	Do.
1254	Ford	1939	Station wagon	1,047	56,874	Do.
339	Pontiac	1940	Sedan	1,139	68,546	New Orleans, La., awaiting disposition.
890	Buick	1947	do	2,860	43,534	New Orleans, La.
1255	Dodge	1942	Station wagon		72,000	New Orleans, La., awaiting disposition.
1486	Buick	1948	Sedan	1,318	26,703	New Orleans, La.
3855	Ford	1949	do	2,053	37,010	New Orleans, La., awaiting disposition.
3979	Buick	1950	do	10,010	19,723	New Orleans, La.
4077	Buick	1950	do	3,992	22,753	Philadelphia, Pa.

3855	Ford	1949	do	2,053	37,010	New Orleans, La., awaiting disposition.
3979	Buick	1950	do	10,010	19,723	New Orleans, La.
108	Ford	1947	do	3,993	22,753	Philadelphia, Pa.
892	do	1950	do	1,944	9,959	Do.
3920	Pontiac	1949	do	598	9,736	Do.
4277	Ford	1952	do	1,308	1,308	Do.
216	Pontiac	1948	do	Unknown	48,711	Portland, Maine.
335	Chevrolet	1942	do	None	55,992	Sabine, Tex.
4084	Pontiac	1951	do	7,278	18,420	Do.
1468	Buick	1947	do	3,455	28,257	San Diego, Calif.
893	Ford	1950	do	2,725	12,256	San Francisco, Calif.
4079	Pontiac	1951	do	2,458	7,912	Savannah, Ga.
235	do	1948	Station wagon	8,742	74,252	Seattle, Wash.
251	do	1948	do	6,438	60,426	Seattle, Wash. (assigned to Portland, Oreg.).
3857	Ford	1949	Sedan	5,351	54,112	Seattle, Wash.
4271	do	1952	do	5,689	5,689	Do.
4272	do	1952	do	9,570	9,570	Seattle, Wash. (assigned to Portland, Oreg.).
103	Willys	1948	Station wagon	1,869	24,225	Staten Island, N. Y. (Rosebank).
106	Plymouth	1947	Sedan	3,241	39,621	Do.
318	Packard	1940	do	2,511	20,402	Do.
320	Chevrolet	1939	Station wagon	3,120	40,042	Do.
2203	Ford	1950	Sedan	2,425	7,642	Do.
2444	Plymouth	1942	do	3,848	53,118	Do.
4077	Pontiac	1951	do	1,277	6,062	Do.
4075	Ford	1952	do	384	449	Do.
241	do	1950	do	6,152	23,842	Tampa, Fla.
803	Plymouth	1947	do	3,006	59,374	Do.
112	Pontiac	1949	do	6,408	42,680	Terminal Island, Los Angeles, Calif.
1239	do	1948	Station wagon	2,855	35,567	Do.
1962	Kaiser	1950	Sedan	6,414	23,581	Do.
2245	Ford	1942	do	2,746	80,972	Do.
4254	Plymouth	1942	do	4,551	17,937	Do.
3748	Buick	1947	do	5,017	42,837	Washington, D. C.
476	do	1947	do	3,739	21,737	San Juan, P. R.
4357	Ford [2]	1953	do			Baltimore, Md.
4356	do [2]	1953	do			Fort Monroe, Va.
4358	do [2]	1953	do			Mobile, Ala.

FOREIGN CARS

2241	Ford	1942	Sedan	(1)	(1)	Anchorage, Alaska.
1247	Chevrolet	1938	do	(1)	(1)	Honolulu, T. H.
2894	Buick	1948	do	(1)	(1)	Do.
3948	Pontiac	1942	do	(1)	(1)	Do.
3949	Ford	1949	do	(1)	(1)	Do.
3985	Buick	1950	do	(1)	(1)	Do.
A-1635	Ford	1947	do	(1)	(1)	Paris, France.
221	Buick	1948	do	(1)	(1)	Do.
2366	Chevrolet	1950	do	(1)	(1)	Do.
3288	Buick	1947	do	(1)	(1)	Do.
3897	do	1947	do	(1)	(1)	St. Thomas, V. I.

[1] Mileage figures not available.
[2] The above 3 cars acquired subsequent to Dec. 31, 1952. Mileage figures not required.

Passenger-carrying motor vehicles on hand as of Mar. 25, 1953 (includes passenger cars, station wagons, ambulances, and buses)—Continued

BUREAU OF STATE SERVICES

SALARIES, EXPENSES, AND GRANTS, NATIONAL HEART INSTITUTE, PUBLIC HEALTH SERVICE

Tag No.	Make	Year	Body style	Mileage driven, July 1 to Dec. 31, 1952	Cumulative mileage as of Dec. 31, 1952	Use and location as of Mar. 25, 1953
FS-157	Packard-Henney	1941	Ambulance	500	34, 770	Charleston, S. C.: On loan to State health department.
FS-787	Pontiac	1948	Sedan	986	30, 400	Charleston, S. C.: Used by heart demonstration unit.
FS-2161	Kaiser	1950	do	895	14, 600	Pittsburgh, Pa.: Mass X-ray survey.
FS-3100	Pontiac	1949	do	1, 371	19, 616	Charleston, S. C.: Used by heart demonstration unit.
FS-4159	do	1951	do	1, 235	13, 454	Washington, D. C.: Used by photographer assigned to Radiology Section to commute between headquarters and laboratory in Rockville, Md.
FS-4160	do	1951	do	1, 422	6, 413	Dallas, Tex.: Used by personnel to render consultative services in diabetes.
FS-4161	do	1951	do	4, 900	10, 270	Los Angeles, Calif.: Used by personnel to render consultative services in heart demonstration unit.

DENTAL HEALTH ACTIVITIES, PUBLIC HEALTH SERVICE

FS-231	Pontiac	1948	Station wagon	3, 155	54, 857	Barnstable, Mass.: Used by dental personnel for consultative services in detal health activities.
FS-560	Chevrolet	1948	Sedan	4, 694	38, 377	Baltimore, Md.: Used for vessel inspections in Baltimore area.
FS-781	Pontiac	1948	Station wagon	942	35, 138	Springfield, Ill.: Consultation on topical fluoride, water fluoridation, and defluoridation.
FS-792	Ford	1946	Sedan	2, 601	26, 932	Woonsocket, R. I.: Declared surplus.
FS-1874	Pontiac	1948	Station wagon	0	66, 200	North Dakota: Used by State health department to promote fluoridation program.
FS-2443	Ford	1946	Sedan	120	23, 150	Cleveland, Ohio: Declared surplus.
FS-2500	Pontiac	1949	do	4, 793	38, 753	Denver, Colo.: Used by dental personnel for consultative services in dental health program.
FS-2914	do	1949	do	3, 378	62, 953	Atlanta, Ga.: Used by dental personnel for consultative services in dental program.
FS-3069	do	1949	do	1, 677	38, 430	Kansas City, Mo.: Used dental personnel for consultative services in dental health program.
FS-3091	do	1949	do	5, 660	44, 549	Dallas, Tex.: Used by mental health consultants to visit points in region concerning mental health activities.
FS-3451	do	1948	Station wagon	1, 979	37, 078	Hartford, Conn.: Consultation on topical fluoride, water fluoridation and defluoridation.
FS-3455	do	1948	do	3, 876	44, 740	Providence, R. I.: Used by State health department to promote fluoridation program.
FS-3456	do	1948	do	0	25, 000	Puerto Rico: Declared surplus.
FS-3461	do	1948	do	0	36, 379	Concord, N. H.: Unserviceable.
FS-3463	do	1948	do	3, 112	28, 637	Denver, Colo.: Used by State health department to promote fluoridation program.
FS-3464	do	1948	do	7, 248	40, 828	Colorado: On loan to Bureau of Indian Affairs to assist the conducting a community service program.
FS-3469	do	1948	do	5, 773	47, 202	Denver, Colo.: Used in establishing and improving local dental health program.
FS-3470	do	1948	do	5, 353	43, 070	Springfield, Ill.: Consultation on topical fluoride, water fluoridation and defluoridation.
FS-3475	do	1948	do	1, 286	25, 398	Washington, D. C.: Used in connection with cooperative agreements with health department.

FS-3475	do	1948	do	1,286	25,398	Washington, D. C.: Used in connection with cooperative agreements with health department.
FS-3481	do	1951	Sedan	5,201	10,798	New York, N. Y.: Used by dental consultants for consultative service in dental health program.
FS-3482	do	1951	do	10,804	17,201	Atlanta, Ga.: Used by dental personnel for consultative services concerning dental program.
FS-3795	do	1948	Station wagon	0	32,231	Chicago, Ill.: Reported surplus awaiting disposition.
FS-3796	do	1948	do	0	27,820	Do.
FS-3797	do	1948	do	1,043	40,173	Columbus, Ohio: Consultation on topical fluoride, water fluoridation and deflouridation.
FS-3799	do	1948	do	6,654	27,132	Nevada: Used by dental demonstration unit.
FS-3800	do	1948	do	3,319	29,006	Colorado: Used by State health department to promote fluoridation program.
FS-3926	do	1949	Sedan	3,198	37,964	Washington, D. C.: Used in connection with cooperative agreements with health department.
FS-3928	do	1949	do	6,462	36,214	Boston, Mass.: Used by regional office consultants to visit States in region for consultative services.
FS-3929	do	1949	do	5,282	37,686	San Francisco, Calif.: Used by dental personnel for consultative services in dental health program.
FS-3932	do	1949	do	5,622	32,061	Chicago, Ill.: Used in establishing and improving local dental health program.
FS-3987	do	1951	Station wagon	637	7,519	Hawaii: Used by dental personnel for consultative services on dental health program.
FS-3988	do	1951	Sedan	3,805	15,271	Chicago, Ill.: Used by dental personnel for consultative services on dental health program.
FS-4002	do	1951	Station wagon	6,981	22,541	Florida: Used in connection with cooperative agreements with State health department.
FS-4003	do	1951	do	4,884	18,836	Alabama: Used in establishing and improving local dental program.
FS-4004	do	1951	do	4,773	14,760	South Carolina: Used in connection with comparative agreements with health department.
FS-4005	do	1951	do	2,003	13,196	Louisiana: Used in connection with cooperative agreements with health department.
FS-4006	do	1951	do	5,790	15,386	Charleston, W. Va.: Used in connection with cooperative agreements with health department.
FS-4011	do	1951	do	6,138	21,700	Dallas, Tex.: Used by dental personnel for consultative services on dental health program.
FS-4063	do	1951	do	4,188	13,901	Arizona: Consultation on topical fluoride, water fluoridation and defluoridation.
FS-4182	do	1948	do	5,448	61,171	New York City: Used in connection with cooperative agreements with health department.
FS-4183	do	1948	do	108	38,109	Burlington, Vt.: Consultation on topical fluoride, water fluoridation and defluoridation.
FS-4359	do	1953	do	0	0	Kansas City, Mo.: Used by dental personnel for consultative services on dental health program.
FS 4362	do	1953	do	0	0	Providence, R. I.: Used in connection with cooperative agreements with health department.
FS-4363	do	1953	do	0	0	Barnstable, Mass.: Used in connection with cooperative agreements with health department.
FS-4364	do	1953	do	0	0	Concord, N. H : Used in connection with cooperative agreements with health department.
FS-4365	do	1953	do	0	0	Boston, Mass.: Used in connection with cooperative agreements with health department.
FS-4366	do	1953	do	0	0	Tennessee: Used in connection with cooperative agreements with health department.
FS-4367	do	1953	do	0	0	Delaware: Used in connection with cooperative agreements with health department.
FS-4368	do	1953	do	0	0	New York: Used in connection with cooperative agreements with health department.
FS-1306	do	1948	do	4,223	46,251	As above (trade-in on P. O. 383).
FS-3452	do	1948	do	3,453	22,525	Delaware program (trade-in P. O. 383).
FS-3474	do	1948	do	(1)	(1)	Tennessee program (trade-in P. O. 383).

[1] Mileage figures not available.

Passenger-carrying motor vehicles on hand as of Mar. 25, 1953 (includes passenger cars, station wagons, ambulances, and buses)—Continued

NATIONAL INSTITUTES OF HEALTH

OPERATING EXPENSES

Tag No.	Make	Year	Body style	Mileage driven, July 1 to Dec. 31, 1952	Cumulative mileage as of Dec. 31, 1952	Use and location as of Mar. 25, 1953
6737	Ford	1952	Sedan	3,789	6,869	National Institutes of Health headquarters, Bethesda, Md. (1) [3]
6887	do	1947	do	8,146	42,096	Do. (1)
6888	do	1949	do	2,082	20,601	Do. (1)
6892	Buick	1941	do	1,409	17,349	Do. (1)
6895	do	1947	do	2,693	38,396	Do. (1)
6898	Pontiac	1951	do	799	5,145	Do. (1)
6899	do	1951	do	4,418	16,481	Do. (1)
6901	do	1948	Station wagon	7,867	57,364	Do. (1)
6903	Buick	1947	Sedan	3,762	50,614	Do. (1)
6904	do	1948	do	2,845	50,048	Do. (1)
6907	do	1947	do	4,017	50,822	Do. (1)
6908	Pontiac	1950	do	6,359	32,460	Do. (1)
6910	do	1950	do	1,290	15,696	Do. (1)
6912	do	1951	do	7,131	11,850	Do. (1)
6913	do	1951	Station wagon	5,328	14,916	Do. (1)
6915	do	1950	Sedan	2,011	16,767	Do. (1)
6919	do	1950	do	3,341	15,667	Do. (1)
6921	do	1950	do	3,437	30,643	Do. (1)
6935	Ford	1949	do	1,589	29,917	Do. (1)
6937	Buick	1947	Sedan	2,499	38,474	Bethesda, Md. (1)
6941	Pontiac	1951	do	2,031	7,310	Do. (1)
6942	do	1949	do	6,688	32,641	Bethesda, Md. (1)
6943	do	1948	Station wagon	9,031	50,391	Do. (1)
6944	Ford	1952	Sedan	3,056	3,056	Do. (1)
6948	do	1948	do	1,718	37,444	Do. (1)
7216	Buick	1946	do	3,729	40,318	Do. (1)
FS-172	Plymouth	1942	do	2,269	57,074	Milledgeville, Ga. (5)
FS-468	Chevrolet	1940	do	155	89,168	Memphis, Tenn. (5)
FS-786	Ford	1947	do	1,624	44,747	Do. (5)
FS-804	Buick	1947	do	1,979	33,109	Do. (5)
FS-1624	Ford	1950	do	2,258	15,984	Nashville, Tenn. (NIAMD). (3)
FS-1626	Pontiac	1950	do	1,462	14,519	Columbia, S. C. (5)
FS-1627	do	1950	do	5,867	33,582	Milledgeville, Ga. (5)
FS-3074	do	1949	do	2,626	21,697	Columbia, S. C. (5)
FS-3193	Ford	1947	do	3,383	33,379	Memphis, Tenn. (5)
FS-3219	do	1947	do	1,771	50,669	Hamilton, Mont. (2)
FS-3227	do	1947	do	717	34,533	Seagoville, Tex. (5)
FS-3272	do	1947	do	1,382	44,951	Columbia, S. C. (5)

FS-3410	Pontiac	1950	do	2,823	15,631	Hamilton, Mont. (2)
FS-3858	do	1948	Station wagon	6,663	51,492	Do. (2)
FS-3874	do	1948	do	6	37,272	Memphis, Tenn. (5)
None	Ford	1942	Sedan			Guatemala City, Guatemala. (9)
National Heart Institute, Salaries, Expenses and Grants						
6806	Pontiac	1951	do	2,678	9,520	Bethesda, Md. (1).
6886	Ford	1947	do	1,384	32,756	Do. (1).
6894	Buick	1948	do	3,863	46,800	Do. (1).
6896	Pontiac	1950	do	3,332	17,000	Do. (1).
6916	Ford	1951	do	4,189	15,428	Do. (1).
FS-234	Pontiac	1949	Sedan	4,813	25,357	Framingham, Mass. (4).
FS-3999	do	1949	do	2,437	30,196	Do. (4).
FS-3997	Ford	1951	do	5,157	18,364	Baltimore, Md. (8).
Dental Health Activities, National Institute of Dental Research						
6902	Pontiac	1950	Sedan	4,196	21,173	Bethesda, Md. (1).
Mental Health Activities, National Institute of Mental Health						
6949	Ford	1948	Sedan	2,010	36,804	Bethesda, Md. (1)
6950	Pontiac	1949	do	5,992	34,964	Do. (1)
6951	Buick	1948	do	6,814	47,710	Do. (1)
National Cancer Institute, Salaries, Expenses, and Grants						
6890	Pontiac	1951	Sedan	1,618	4,605	Bethesda, Md. (1)
6891	Ford	1949	do	2,136	27,546	Do. (1)
6893	do	1949	do	2,983	30,639	Do. (1)
6906	Pontiac	1950	do	6,557	22,752	Do. (1)
6914	Ford	1947	do	508	39,359	Do. (1)
FS-3194	do	1947	do	3,131	44,702	Baltimore, Md. (8)
FS-3217	do	1947	do	5,870	27,713	Memphis, Tenn. (7)
FS-3853	do	1949	do	1,199	15,983	San Francisco, Calif. (6)
FS-3854	Pontiac	1948	Station wagon	6,128	38,389	Memphis, Tenn. (7)

[1] See statements of use, at end of table, corresponding to numbers in parentheses.

STATEMENTS OF USE, NATIONAL INSTITUTES OF HEALH VEHICLES

(1) Used by scientific, medical, technical, and administrative personnel of the seven institutes, Office of the Director, Clinical Center and the Division of Research Grant in connection with—

(*a*) Transacting the day-to-day official business in and around Bethseda, Md., and Washington, D. C., such as attending staff and other official meetings and transportation to other Government agencies.

(*b*) Trips to other Government agencies such as Bureau of Standards, naval ordnance laboratories, naval research laboratories, and the Department of Agriculture at Beltsville, Md., for the purpose of consulting and collaborating with scientists and others regarding studies, and projects of mutual interest.

(*c*) To visit research projects being carried on at removed points such as Baltimore, Norfolk, and Hagerstown.

Full-scale operation of the Clinical Center will increase the use of these vehicles in connection with—

(*a*) Investigating, examining, and admitting prospective patients;

(*b*) Consultation and collaboration with physicians, surgeons, and medical institutions regarding individual cases; and

(*c*) Providing transportation to patients from nearby points as necessary.

(2) Used in connection with the study of diseases of particular importance to Western States. It is necessary to conduct these studies in animal or orthropod reservoirs in their natural environment. Because this environment is usually in rural or mountainous areas it is necessary to have vehicular transportation.

(3) Assigned to Medical Director Harold R. Sandstead to facilitate his operation with the Department of Biochemistry and Nutrition of the Vanderbilt University School of Medicine and the Central State Hospital, 11 miles distant, and for conducting field investigations and surveys in nutrition and metabolism.

(4) Epidemiology study, Framingham, Mass. The vehicles assigned to this study are used to:

(*a*) Contact physicians, industrial establishments, and private homes in order to obtain volunteers and stimulate participation of the Framingham population in this study which involves some 10,000 persons;

(*b*) Maintain daily contact with participating laboratories located in the Massachusetts General Hospital which is 22 miles from Framingham;

(*c*) Transport blood samples between the study clinic and the laboratories; and

(*d*) Contact persons at the hospital and the Harvard School of Medicine for consultative purposes.

(5) These vehicles are assigned to the respective field stations of the Laboratory of Tropical Medicine, National Microbiological Institute. These stations conduct studies on basic factors concerning the national history of parasitic diseases, such as transmission and relation of individual community and other environmental factors to parasite distribution and incidence; host-parasite-vector relationships; immune responses of parasite, vector, and host; and studies on the basic cytology and morphology of parasites and relation of these factors to parasite genetics, strain variability, and virulence.

The vehicles are used by station personnel to canvass large segments of the rural population to obtain information and to collect specimens. The research work also requires the collection of wild insects and animals from the surrounding countryside and other parts of the States to determine the presence of various species of vectors or hosts of parasitic diseases.

(6) Assigned to Laboratory of Oncology, National Cancer Institute, for use on a cooperative study with the Medical School of the University of California. These activities require travel at intervals which do not coincide with public carrier schedules and the distance between the school and laboratory would make the use of taxicabs prohibitive.

(7) Being used in a cooperative study involving the Cancer Investigation Unit, National Cancer Institute, the city of Memphis and adjacent area. The vehicles are used to make frequent pickups and deliveries of specimens and cytologic kits from physicians, clinics, and offices, and to transport personnel and equipment to various industrial plants for the purpose of carrying on cytological studies.

(8) Used by heart and cancer activities in the pickup of emergency supplies and mail and for transporting personnel and equipment between projects located in the Public Health Service Hospital and the Baltimore City Hospital.

(9) This vehicle assigned to the onchocerciasis project being cooperatively conducted by the Laboratory of Tropical Diseases, National Microbiological Institute, and the Pan American Sanitary Bureau. It was obtained without charge from the Albrook Air Force Base, C. Z., and its operation and maintenance is financed by the Pan American Sanitary Bureau. It is used as necessary means of transacting the day-to-day business of the project.

Passenger-carrying motor vehicles on hand as of Mar. 25, 1953 (includes passenger cars, station wagons, ambulances, and buses)

OFFICE SURGEON GENERAL

SALARIES AND EXPENSES, PUBLIC HEALTH SERVICE

Tag No.	Make	Year	Body style	Mileage driven, July 1 to Dec. 31, 1952	Cumulative mileage as of Dec. 31, 1952	Use and location as of Mar. 25, 1953
2424	Buick	1947	Sedan	1,427	50,725	Washington, D. C.: Used by headquarters personnel for conducting official business in the metropolitan area of Washington, D. C., and for field trips when travel cannot be performed by common carrier or when transportation by vehicle is cheaper than transportation by common carrier.
5014	Pontiac	1950	do	3,136	20,786	
5019	do	1950	do	2,053	15,217	
5458	do	1950	do	1,094	8,291	
6017	do	1951	do	3,546	12,510	
6018	do	1951	do	5,434	12,995	
7358	do	1948	do	355	21,949	
6475	do	1951	do	1,075	3,024	Washington, D. C.: Assigned to the Office of the Surgeon General for his use and the use of his immediate staff.
FS-2246	Ford	1942	do	705	12,500	Medical Supply Depot, Perry Point, Md. Because of the isolated location of the station, transportation is required for: (*a*) Trips to the railroad station and post office for official mail, small packages, and official visitors to the station; (*b*) trips to business establishments in Perryville for emergency supplies and equipment; and (*c*) trips to Washington, D. C., and Baltimore, Md., when transportation for more than 1 person is involved and cost is less than common-carrier-transportation costs.
FS-4253	Buick	1948	do	947	27,600	

NOTE.—Vehicle 2424 declared excess Feb. 23, 1953. Vehicle 7358 in use at this location since Oct. 28, 1952. Vehicles FS-2246 and FS-4253 in process of disposal as excess.

Mr. FOGARTY. Mr. Harlow, are these cars traded in on the Budget Bureau's formula of 6 years or 60,000 miles?

Mr. SEGGEL. That is correct, sir.

Mr. FOGARTY. Is that the same formula used by the Government in replacement of all cars?

Mr. HARLOW. I think it is.

Mr. FOGARTY. They consider that the economical time to replace a car?

Mr. HARLOW. Yes.

Mr. FOGARTY. After that it is usually uneconomical to keep them?

Mr. HARLOW. Yes. I think that was established to the satisfaction of the Budget Bureau by several surveys.

PREVIOUS APPROPRIATIONS

Mr. FOGARTY. I notice that in 1946 your appropriation was $11 million, but then in 1947 you requested $19 million. I remember that there was a reason, but I cannot remember specifically what it was. I know you asked for an increase, and we did not go along with the idea of taking away from other categorical programs and putting it into this overall program. Is that not it?

Mr. HARLOW. Yes, that is principally the thing there, Mr. Fogarty. The idea was at that time to gradually work away from what we call categorical grants into a general-grant program. In fact, it was along about that time or soon thereafter that there was considerable push behind the bill that was in Congress for assistance to local health units, as you may recall, for a kind of general grant to build up local health units in the country.

I think the history of that thing, although I may not have the year exactly, was that Congress pretty generally accepted our cuts in the categories, maybe did not make them quite so stringent as was proposed in the budget, but did not go along in the increase in the general-grant item.

Mr. FOGARTY. We went along with the cuts you proposed in the categorical programs, but we did not allow you the increases you asked for in this program, and as a result these programs were cut.

Mr. HARLOW. Let's put it that we made a tactical error, perhaps.

Mr. FOGARTY. I often wondered why you kept urging this thing, because I remember that when Mr. Keefe was chairman, he never really approved of this overall general grant program either; he wanted to keep funds in categorical divisions so that anyone could find out what we were spending on each activity.

Mr. HARLOW. Mr. Chairman, we do not always have the final determination in the Public Health Service as to how these budgets shall come up here.

BACKLOG OF NATIONAL OFFICE OF VITAL STATISTICS

Mr. FOGARTY. This program of vital statistics is important to the health needs of the Nation, is it not?

Dr. HALDEMAN. Extremely so.

Mr. FOGARTY. You are apparently far behind now?

Dr. HALDEMAN. That is correct.

Mr. FOGARTY. You used a 1947 figure in your testimony. Does that mean you are that far behind?

Mr. HALDEMAN. No, sir. We are a year behind now on our expected schedule and are falling behind, as I said, all the time, in spite of the fact that we have dropped temporarily certain necessary tabulations and have delayed some very essential work.

If I might just take a minute to tell you some of those things.

Mr. FOGARTY. Yes.

Dr. HALDEMAN. For instance, for the next year or two, in order to overcome this backlog, we will have to drop out residence statistics of birth and death in cities and towns.

As you know, people are born and die by and large in hospitals these days, in the larger towns. That means that when you try to evaluate the progress in health in a given city or in rural versus urban area, you need to tabulate place of residence in addition to the place where the occurrence was. We were able to save 7 clerk-years by dropping this temporarily, but we need to pick it back up.

We are only tabulating a sample of the birth certificates, which introduces some errors which cannot continue.

We are dropping such things as classification of institutions where death occurred.

We also have not developed the United States life tables on a decennial basis since 1940.

We had to drop our study on deaths from motor-vehicle accidents, upon which a lot of our national safety program has been based. That must be dropped just temporarily, but we felt for a year or two until we caught upon this backlog we could get by in doing that.

Mr. FOGARTY. How does that affect the health needs of the country?

Dr. HALDEMAN. Dropping reports on the motor-vehicle accidents?

Mr. FOGARTY. Yes; or any one of those things.

Dr. HALDEMAN. It is essential that you have your basic data regarding occurrence of deaths, birth, and occurrence of communicable disease in order to provide guidelines for program planning and in reevaluating your program in order to direct it at the more profitable avenues.

For instance, a city health officer wants to know what is happening to his infant death rate or to his maternal death rate, and how his rate compares with those of other cities. If his rate is higher, he feels he had better get to work with the hospitals and pediatricians and will direct his public-health program into those areas. The annual statistical report is our national guideline.

I might mention that there has been a revision of the international schedule of causes of death, which is done every 10 years, but the result has been that it introduces errors. For instance, we watch what is happening in a disease such as diabetes over a period of years. Because of the change in coding which went into effect in 1948, the way the statistics came out it would have appeared that diabetes deaths had been cut in half, which is not so. The reason is that, under the new coding rules, the diabetes does not take precedence over other causes of death that may be reported with it, to the extent it did. We need to study and to redefine guidelines in order to get national trends that are significant and where we are going in fields like diabetes.

Mr. FOGARTY. The death rate in diabetes has come down, has it not, since the use of insulin?

Dr. HALDEMAN. I cannot answer that. I am under the impression, however, that diabetes—I feel confident in saying that the death rate from diabetes in the last few years has been increasing.

The reason is, although insulin will prolong life, diabetics still develop cardiovascular disease at a much earlier age and the life expectancy of a diabetic even under insulin therapy is much shorter than that of a person without diabetes. And as we develop an aging population, even with the stabilizing influence of insulin, our death rate from diabetes is increasing.

Mr. FOGARTY. The development of an aging population has also made the gathering of disease statistics more important.

Dr. HALDEMAN. That is correct.

Mr. FOGARTY. You have had various changes.

Dr. HALDEMAN. Yes. Today with more of an aging population we have upon the average death certificate more than one cause of death. As a matter of fact, three-fourths of the death certificates report multiple causes of death.

One of the types of things which we have not been able to undertake is to relate second and third causes of death, because on the tabulation at the present time we can only take the cause of death given as the principal cause of death. We cannot analyze the contributing factors on the death certificates because it takes that many more clerks to punch the cards.

You see, essentially, our vital statistics job is one in which before you do anything with your national statistics, you have got to punch all the cards and tabulate them. That basic job of tabulating over a million and a half deaths and almost 4 million births is a constant thing. Of course, it is increasing as the number of deaths and births increase. From there on you could do a tremendous amount of very vital analyses that are useful as guides for health. But it is in this basic job of doing the tabulating that we cannot reduce the costs. I mean we can effect no more economies.

Mr. FOGARTY. I remember that I asked 4 or 5 years ago how many people died from or were affected by multiple sclerosis, and I do not think there were any statistics on that disease at all. There was just a guess made at the time.

Dr. HALDEMAN. Yes.

Mr. FOGARTY. I presume the same would be true in the case of muscular distrophy. We do not know how many people die of that a year, do we?

Dr. HALDEMAN. No.

Another very important area which we have not gotten into—I am sure you gentlemen are aware of the fact that perhaps one of our greatest gains in health in the last few years has been the reduction in infant mortality; that is, deaths in children from a few days old up to a year. We have a large problem to which we have not addressed ourselves—the analysis of the deaths in the latter months of foetal life, in other words, the stillbirths or the babies who live just a few hours.

Our present certificates which we get from States do not give us much information on this type of thing as to the cause of the mother's condition or the foetus' or infant's condition. Getting this will require working with the States in developing a new and uniform type of report, going into some of the underlying causes. Today all we get is,

"stillborn." We do not even get adequate description of the foetal age at birth.

That is another type of activity which we have had to postpone.

Mr. FOGARTY. That is all.

Mr. BUSBEY. Mr. Harlow, do I recall correctly that you made a remark this morning regarding some vital statistics that are gathered in the Office of the Surgeon General?

Mr. HARLOW. No, sir.

Mr. BUSBEY. All the vital statistics are collected in this one place?

Mr. HARLOW. What we had under consideration at that time, Mr. Chairman, was an item that was in the Office of the Surgeon General to pay the Office of Vital Statistics for some tabulating work that they do for them. That was not vital statistical tabulation; that was principally on accounts and personnel data.

Mr. BUSBEY. Is there any place that vital statistics are gathered outside of this one Bureau?

Dr. HALDEMAN. All our vital statistics relating to births and deaths and communicable diseases are gathered and processed by the National Office of Vital Statistics.

THURSDAY, MARCH 26, 1953.

CONTROL OF COMMUNICABLE DISEASES

WITNESSES

DR. JUSTIN M. ANDREWS, ASSOCIATE CHIEF, BUREAU OF STATE SERVICES

LEONARD B. ABBEY, BUDGET AND FISCAL OFFICER, COMMUNICABLE DISEASE CENTER

DR. OTIS L. ANDERSON, CHIEF, BUREAU OF STATE SERVICES

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$6,188,397	$5,919,750	$5,735,000
Transferred to "Salaries and expenses defense production activities, Federal Security Agency," pursuant to Public Law 253	−25,000		
Adjusted appropriation or estimate	6,163,397	5,919,750	5,735,000
Reimbursements from non-Federal sources	6,336		
Reimbursements from other accounts	450,442	382,010	300,000
Total available for obligation	6,620,175	6,301,760	6,035,000
Unobligated balance, estimated savings	−23,516		
Obligations incurred	6,596,659	6,301,760	6,035,000
Comparative transfer to "Salaries and expenses, Public Health Service"	−12,000	−15,000	
Total obligations	6,584,659	6,286,760	6,035,000

NOTE.—Reimbursements from non-Federal sources above are from the proceeds of sale of personal property (40 U. S. C. 481 (c)).

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
Direct Obligations			
1. General disease-prevention and control activities	$4,172,318	$4,151,700	$4,100,000
2. Specific disease-prevention and control activities	1,415,026	1,216,050	1,100,000
3. General epidemic and disaster aid	34,891	40,000	40,000
4. Administration	511,982	497,000	495,000
Total direct obligations	6,134,217	5,904,750	5,735,000
Obligations Payable Out of Reimbursements From Other Accounts			
1. General disease-prevention and control activities	367,450	382,010	300,000
3. General epidemic and disaster aid	82,992		
Total obligations payable out of reimbursements from other accounts	450,442	382,010	300,000
Total obligations	6,584,659	6,286,760	6,035,000

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Summary of Personal Services			
Total number of permanent positions	1,402	1,294	1,255
Full-time equivalent of all other positions	9	8	8
Average number of all employees	1,169	1,103	1,071
Average salaries and grades:			
General schedule grades:			
Average salary	$3,844	$3,830	$3,840
Average grade	GS-5.0	GS-5.0	GS-5.0
Crafts, protective, and custodial grades:			
Average salary	$2,974	$2,991	$2,987
Average grade	CPC-4.0	CPC-4.1	CPC-4.1
Personal service obligations:			
Permanent positions	$4,881,173	$4,732,664	$4,588,911
Part-time and temporary positions	27,052	24,116	24,116
Regular pay in excess of 52-week base	13,663	11,920	11,516
Payment above basic rates	20,178	6,600	6,600
Total personal service obligations	4,942,066	4,775,300	4,631,143
Direct Obligations			
01 Personal services	4,730,940	4,584,590	4,449,793
02 Travel	296,759	279,400	274,600
03 Transportation of things	90,710	87,800	87,100
04 Communication services	57,228	57,300	56,850
05 Rents and utility services	85,676	86,350	86,350
06 Printing and reproduction	27,906	26,400	26,400
07 Other contractual services	96,452	84,400	81,150
Services performed by other agencies	21,163	5,000	5,000
08 Supplies and materials	475,580	427,102	402,029
09 Equipment	230,009	214,500	214,200
10 Lands and structures	8,685		
13 Refunds, awards, and indemnities	709	600	600
15 Taxes and assessments	13,874	12,950	12,570
Unclassified (general epidemic and disaster aid)		40,000	40,000
Subtotal	6,135,691	5,906,392	5,736,642
Deduct charges for quarters and subsistence	1,474	1,642	1,642
Total direct obligations	6,134,217	5,904,750	5,735,000
Obligations Payable Out of Reimbursements From Other Accounts			
01 Personal services	211,126	190,710	181,350
02 Travel	20,609	16,000	10,000
03 Transportation of things	1,442	1,000	700
04 Communication services	665	500	300
07 Other contractual services	16,195	14,500	8,400
08 Supplies and materials	159,786	127,000	80,000
09 Equipment	40,308	32,000	19,000
15 Taxes and assessments	311	300	250
Total obligations payable out of reimbursements from other accounts	450,442	382,010	300,000
Total obligations	6,584,659	6,286,760	6,035,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$994,024	$587,606	$536,356
Obligations incurred during the year	6,596,659	6,301,760	6,035,000
	7,590,683	6,889,366	6,571,356
Deduct:			
Reimbursable obligations	456,778	382,010	300,000
Adjustment in obligations of prior years	241,282		
Unliquidated obligations, end of year	587,606	536,356	546,356
Obligated balance carried to certified claims account	20,451		
Total expenditures	6,284,566	5,971,000	5,725,000
Expenditures are distributed as follows:			
Out of current authorizations	5,635,690	5,446,000	5,220,000
Out of prior authorizations	648,876	525,000	505,000

Mr. BUSBEY. We have before us for consideration this morning the appropriation request for control of communicable diseases of the Public Health Service for fiscal year 1954.

I believe you have a general statement for the committee, Doctor.

GENERAL STATEMENT

Dr. ANDREWS. Mr. Chairman and members of the committee, communicable and other preventable diseases continue to exact a great toll of life, health, and money in the United States. Steady improvement has been made in treatment with drugs, in disease prevention with vaccines and sera, in reductive measures against insects and rodents which spread disease, and in the techniques of environmental sanitation. Not only have pestilences which previously desolated large areas been conquered, but it has been shown that many of these diseases can be virtually exterminated. In spite of these achievements, over 100,000 persons die of acute communicable disease each year, unknown millions of cases occur, and industry loses $2¼ billion due to communicable disease absenteeism. Thus much remains to be done. Safer, cheaper, and more effective methods of control should and can be discovered and demonstrated to the practicing health personnel of the Nation.

The item, "Control of communicable diseases," is used to support the Communicable Disease Center which exists to help the States control certain communicable and preventable illnesses where these problems tax or exceed State resources, are interstate, or are federally created. This is accomplished (1) by carrying out field and laboratory studies for developing better techniques, materials, and equipment to be used in the diagnosis and prevention of these diseases; (2) by making tests and evaluations of these procedures; (3) by demonstrating them to State and local health department personnel; and (4) by training these individuals in their application. The Communicable Disease Center furnishes epidemic aid when requested by State health officers, and provides disaster aid under regional direction and coordination. In fulfilling these obligations it is necessary to maintain at the headquarters in Atlanta and in the field installations of the Communicable Disease Center a variety of professional personnel, including medical, nursing, engineering, training, and diverse scientific skills.

MAJOR ACTIVITIES

Certain of the major activities of the Communicable Disease Center, past and present, include:

1. Investigational or operational assistance, or both, to States in the prevention of malaria; plague, typhus, and other rodent-borne disease; diarrhea spread by flies; rabies; epidemic jaundice; infantile paralysis; sleeping sickness; acute intestinal infections; histoplasmosis and other fungal diseases; infectious conjunctivitis; and other communicable illnesses. Some of them are common, others are rare, but all of them cost time, money, comfort, and in some instances, life.

2. Clinical and experimental studies of the health hazards of certain economic poisons used in insect and rodent control, and the development and testing of antidotes.

3. Investigations of the nature and prevention of the resistance developed by insects against modern insecticides.

4. Methods of preventing the production of mosquitoes of public health importance in federally built reservoirs and irrigation systems.

5. Training and the production of audiovisual training materials for insect and rodent control, laboratory diagnosis, and the field investigation of epidemics.

6. Reference diagnosis of difficult or unusual specimens for State health laboratories.

7. The development of an Epidemic Intelligence Service.

EPIDEMIC WORK

Epidemiologic activities, i. e., those relating to investigations of the frequency, distribution, transmission and prevention of disease, should include continuing field studies of a number of specific infections with emphasis on infantile paralysis and sleeping sickness; epidemic assistance, investigation, and consultation to State and local health departments; surveillance of malaria and typhus; training of epidemiologists; and the further development of the Epidemic Intelligence Service. This latter project is designed to train qualified medical and nonmedical health personnel in the investigation of disease outbreaks with the object of determining their source, nature, and method of production—in particular, whether they are the result of natural influences or are induced by man. Within the limits of its means, this program is attaining its objectives of augmenting the short supply of critically needed, peacetime epidemiologists, and at the same time is creating a byproduct resource of experienced epidemic investigators available for defense against biological warfare. We should continue surveillance of malaria, typhus, and other diseases on the control of which huge sums of Federal and State funds have been spent. This supplies critical information regarding current transmission and the reintroduction of these infections and the feasibility of their eradication. By this means it is known, for example, that malaria, a disease which was nearly extinct in this country in 1950, was imported by military personnel from Korea in 1951 and 1952 and was transmitted in the United States in 1952.

Laboratory activities should continue to include research to improve methods of identifying disease agents; the diagnosis of exceptional or complicated specimens for States; laboratory assistance to States in

epidemics, training, and evaluation; and diagnostic cooperation with communicable disease center field activities. Significant progress is being made in the rapidity and economy of virus isolation and identification by use of tissue cultures and mice instead of live monkeys. It is possible that this method may contribute ultimately to the production of effective vaccines. This is an exceedingly large and complicated problem; work on it is proceeding collaboratively with the National Institutes of Health. The total number of laboratory specimens processed advanced from 100,000 in fiscal 1951 to an estimated 146,000 in fiscal 1953 because of the constantly increasing demand for specialized diagnostic services from the States and the communicable disease center epidemiologic field activities.

The investigation of airborne disease agents should be continued to include improvement of practical air sampling equipment and the development of rapid methods of biological identification.

This is another large and complex field of investigation which is being studied collaboratively both with the National Institutes of Health, and the Enviromental Health Center where studies are being made of chemical and physical methods of agent identification. Information is also being sought concerning the normal bacterial content of air of cities and rural areas to used as a baseline for determining unusual concentrations in peacetime or war.

Vector investigation and control activities should be continued to provide leadership in investigating the ecology of insects and rodents of public health importance; in promoting and demonstrating control projects; in developing new control techniques, materials, and equipment; and in training personnel to their use. Extensive experience with fly control operations in the prevention of diarrhea produces convincing evidence that both general sanitary measures and chemical insecticiding are needed for practical economy, and to avoid the development of flies resistant to these compounds. This last phenomenon also occurs among disease-transmitting mosquitoes and is the subject of intensive study. The 1952 epidemic of encephalitis in California, the largest on record in that State, emphasizes the importance of continuing mosquito investigations and control in the newly irrigated areas of the country where this disease may be expected to occur unless reductive measures are devised and employed. Resistance of the mosquito transmitter to insecticides hampered the control efforts applied in California.

ECONOMIC POISONS STUDIES

Studies should be continued to determine the health hazards associated with the use of economic poisons and to devise means for preventing or ameliorating them. These involve the presence of DDT-type insecticides or of the newer phosphorus-containing compounds, such as parathion, on growing fruits which sometimes become contaminated as a result of insecticidal applications to trees.

It is planned that training specialists will conduct insect and rodent control and other courses within the communicable disease center, and will supervise and coordinate decentralized public health training for State and local health personnel as required in various parts of the country. These services will be expedited and facilitated by the use of specially prepared scientific guides and audiovisual teaching aids.

It is expected that the communicable disease center will continue to provide epidemic and disaster aid to the limits of its resources. In spite of the fact that the expenditures for epidemics rarely involve more than travel costs, nearly three-fourth of the funds available have been spent on 15 epidemics in 13 States during the first half of this fiscal year.

I will be very glad to answer whatever questions I can.

Mr. BUSBEY. On page 2 of your statement, Dr. Andrews, under item 2, you refer to—

clinical and experimental studies of the health hazards of certain economic poisons used in insect and rodent control, and the development and testing of antidotes.

Dr. ANDREWS. Yes, sir.

Mr. BUSBEY. Does this work really come under the heading of communicable diseases?

Dr. ANDREWS. Yes, sir; because the insect and rat control is carried on to prevent the transmission of communicable diseases—rat-borne diseases and insect-borne diseases.

RELATIONSHIP OF INSECT AND RODENT CONTROL PROGRAM TO WORK OF FOOD AND DRUG ADMINISTRATION

Mr. BUSBEY. How does this work in your department differ from the work carried on by the Food and Drug Administration?

Dr. ANDREWS. Our investigations are purely fact-finding activities designed to determine whether the use of these chemicals is injurious to the people who mix these chemicals, to the operators who apply them, to the individuals living in houses where they are used, or to the residents of areas near orchards, for example, where they are employed on a large scale. In other words, these are largely clinical and medical examinations which are made to determine whether or not injury results as a consequence of the use of these compounds.

This work is carried on largely in the fruit-growing area of Washington, in Wenatchee; that is, the main clinical and medical work is carried on there. We do certain supporting animal experimentation in Savannah, Ga., and we have another species of examinations going on in Cleveland, Miss., where rice growing and cotton growing involve the large-scale use of insecticides to which the residents of that area are exposed.

You asked me how this differs from the Food and Drug Administration work. It is my understanding that their functions are largely regulatory, whereas ours are trying to determine the public-health hazard of those poisons. Our quarterly reports are made available to officials of the Food and Drug Administration so that they have an opportunity to keep current with our information, and I am sure much of what we learn is applied by them in the course of their regulatory pursuits.

RELATIONSHIP TO WORK OF DEPARTMENT OF AGRICULTURE

Mr. BUSBEY. What about the overlapping of this work with the Department of Agriculture?

Dr. ANDREWS. I am not aware there is any great overlapping, because we are concerned primarily with the health of the public,

whereas the agricultural work, I assume, concerns primarily determining the efficiency and effectiveness of these preparations in killing pests and crop-injurious insects.

Mr. BUSBEY. You say your reports are available to the Food and Drug Administration, and you admit the Department of Agriculture is doing certain things in this field. Is not there any definite coordination between the three to eliminate any possibility of overlapping of work?

Dr. ANDREWS. Yes, sir. There is what is known as an Interdepartmental Pest Committee which is comprised of membership from the three agencies you have mentioned and also the Army, Navy, and Air Force, which are also vitally interested in the same considerations. Representatives from these agencies meet at frequent intervals, and the work in the interest of all concerned is discussed at those times.

Mr. BUSBEY. The justifications of the Department of Agriculture, for instance, under insect investigations, research objectives, contain the following statement:

> To develop bioassay and chemical methods of measuring trace amounts of insecticidal residues and to evaluate the possible harmful effects of chemical residues occurring on or in plants and animals, or products derived from them, used for human consumption.

It seems to me that both of you are dealing with the factor of possible danger from human consumption.

Further over in its justifications, under "Analytical methods for bensene hexachloride residues," the Department says:

> A method has been developed for the detection of very small amounts of benzene hexachloride. This has proved useful in the analysis of soils and plant products for traces of this insecticide. The tremendous interest in the occurrence and effect of insecticide residues on food products make the development of accurate and specific analytical methods for minute amounts of insecticides especially timely. The above method also has been adapted, by the development of a suitable sampling procedure, to the determination of lindane vapor in air. This is important because of the increasing use of lindane vaporizers for fly control.

In another place under that section captioned "Insecticide Residues Studied," the Department says:

> In cooperation with insecticide manufacturers, studies have been made of the residues resulting from the application of several insecticides. These included an investigation of the amount and distribution of DDT residues on corn resulting from application of different types of DDT spray formulations; a study of the magnitude of malathon residues deposited on various fruits and vegetables from different spray formulations; and an investigation of possible contamination of wheat stored in chlordane-treated bins. These studies have an important bearing on the development of effective and especially the safe uses of insecticides.

Dr. ANDREWS. Of course, they are interested in that, and much of that work is being carried on actually together with our people, because of our interests which do merge at that point. But where our interests are concerned primarily with the health of man, theirs will be concerned, perhaps, with detecting the presence of DDT in the milk of cattle or such food products as that.

The methods which you refer to there were worked out—some of them—in collaboration with our own toxicologists in Savannah. I am sure that through the interdepartmental pest committee and through a special unofficial group which has grown up over the years, which meets annually and just had its meeting in northern Alabama

a week or two ago, representatives of TVA, interested in the toxicology of chemical poisons, and the Department of Agriculture and Public Health Service, meet and discuss their work, and are making further plans for that of the next year so that there will not be any undesirable duplication or overlapping, and everybody will be informed about what the other agency is doing.

Mr. HARLOW. Mr. Chairman, I think it would be proper at this time to go back and give a little past history and point out how we really got into this proposition in Wenatchee, Wash. As a result of action taken by the Appropriations Committee, the Department of Agriculture was directed to transfer certain sums of money to us in order to set up this particular installation out there to do this toxicological work with respect to spray residues and things of that type.

Mr. BUSBEY. From my reading of the three sections I just read into the record from the justifications of the Department of Agriculture, it appeared to me that the Department is dealing with the protection of man as well as animals.

Mr. HARLOW. I do not think there is any question but what the Department of Agriculture has authority to do work that relates to humans; in fact, I think I was reading the basic act with respect to the Research and Marketing Act and I think it used the word "medical" in the basic act.

Dr. ANDREWS. The insecticide labeling, which Production and Marketing controls, is integrated with the recommendations of this interdepartmental pest committee. Much of the information comes from our organization. There is very close collaboration in this entire field. We all have interests which, as I indicated, approach each other, but I do not think there is uneconomical or undesirable duplication of the actual activities.

Mr. BUSBEY. In item No. 3 on page 2 of your prepared statement, you say:

> Investigations of the nature and prevention of the resistance developed by insects against modern insecticides.

Just what is the Department of Agriculture doing in this field?

Dr. ANDREWS. They must have an identical interest in the insectisides which are used for agricultural purposes that we have in the insecticides that are used for communicable disease control purposes. Again, our activities are known to each other currently, and we are able to assist each other in certain phases of this research. For example, we have recently succeeded in making some radioactive DDT which we think will be of great assistance in studying the methods by which DDT is utilized in the bodies of flies, the difference in its utilization by the flies which are resistant to it in comparison with those which are not. It is extremely difficult to produce and we only have 6 grams (about a teaspoon and a half) of this material, which was made over a long period of time, but undoubtedly we will share part of that with the other investigators who are also studying DDT. But the Department of Agriculture is doing that for agricultural purposes; we are using it to prevent human disease. It seems to me we both have a very legitimate interest in this subject.

Mr. BUSBEY. It seems to me there ought to be closer coordination of this work so that one department could make its studies available to all of the other agencies instead of each doing the same studies independently.

Dr. ANDREWS. Very largely, that is what occurs at the meetings of this Interdepartmental Pest Committee. This is an official committee.

Mr. BUSBEY. But when you get together at those interdepartmental meetings, you just have a general discussion of what you have been doing; is not that a fact?

Dr. ANDREWS. I would like to produce some of the proceedings of those meetings for your benefit, if you wish, so that you can see the nature of them. Actually, they go pretty minutely into the accomplishments of the planned activities.

Mr. BUSBEY. Just last week the Bureau of Entomology and Plant Quarantine of the Department of Agriculture was before the Subcommittee on Agriculture Appropriations. Its officials told the committee that they are doing considerable work in this same field, and toward the end of the discussion Mr. Bishopp, Assistant Director, had this to say—I will read from the transcript, quoting Mr. Bishopp:

> I would like to say that we are cooperating closely with many of the agricultural experiment stations and universities. Also, with the military in the development of new insecticides that may accomplish destruction of given pests without undue residue or health hazards. It may be of interest to the committee to know that the military has been strongly behind fundamental work on this problem. It would, perhaps, be more logical for the Department of Agriculture to do most all of the fundamental work on this problem because we have had for years, here in the United States, an organization dealing with the insect world and have the personnel and the facilities, the know-how, to meet these problems. I think we will make very marked advances in the next few years through intimate study of the physiology of the various species of insects and how the resistance actually comes about, and how we may block the development of resistance or through our insect studies develop materials that may be more effective and may not have this tendency to build up resistance among the insects.

Dr. ANDREWS. That is an example of a problem which is large enough and important enough—I alluded to two of them in my opening statement—that, in my opinion, it demands the attention and exploration of as many competent people as you can bring to bear upon it. The addition of one new investigator may throw an entirely new light on the possibility of solving this very embarrassing situation which develops when we can no longer kill insects with insecticides that are used for an agricultural purpose or a communicable-disease control purpose because the insects have developed resistance.

I do not think there is any essential loss of money or manpower in bringing to bear all of the various competencies to those which the Department of Agriculture contributes precisely as they said. We can add certain other competencies which they do not have; that is, the ability to get a mass picture of the effects of these poisons on man himself. Our epidemiologists are available for field study, and we have clinical tests for poisons which can be made on blood and other tissues, e. g. fat tissues of man. As a matter of fact, we have done some of that work for the Food and Drug Administration. The whole

thing fits together to make one more complete and not particularly overlapping picture.

Mr. BUSBEY. The trouble is that these officials go before the Subcommittee on Agriculture Appropriations and from this statement alone it would seem that they would be the only ones in the field; they are taking credit for the whole work. Then we have Communicable Disease officials appear before this committee and tell us about their activities and we also have Food and Drug officials tell us about their activities. But these three agencies are not as bad as some of the others, because in other instances the Appropriations Subcommittees find in the course of years that there may be six or seven agencies of Government handling the same problem.

Now, something has to be done to be sure there is no overlapping of work between the various agencies of the Government. And I am not so sure that there isn't some overlapping between your agency, Food and Drug, and the Department of Agriculture in this work.

Mr. STEPHENS. Mr. Chairman, I remember an occasion before this committee—I think Mr. Albert Thomas was on the committee—when they had an outbreak of typhus in Houston, Galveston, and some west coast ports, and these people found this typhus was carried by fleas going from one rat to another, and the fleas infested the rats and the rats carried it along, and then the fleas would get off the rats and onto the person. I cannot conceive of Agriculture, which is primarily interested in the production of food crops, having anything to do with insecticides for the eradication of fleas. They do not destroy crops; they have nothing to do with the food industry. But this committee, if I remember correctly, put some money in for that purpose on the west coast and Gulf coast to get the answer to typhus, and it was licked and the answer was killing the fleas that transmitted the disease from rats to people. That was 6 or 7 years ago.

Dr. ANDERSON. I would like to make a point that in this area of work it is not one that is actually exclusive for any one organization, and each Department has its peculiar interest and has to establish its priority for it in the area in which there is need. I think that follows very much the thought Mr. Stephens just expressed.

Dr. DEARING. Also, this is in the very nature of research on a very large problem in which, as Dr. Andrews said, all the leads and ideas we can bring to bear on it are not too many, because it is the very heart not only of the agricultural economy but a very large share of our health problems.

Mr. BUSBEY. I am just looking at the Insecticide Act as it is shown in the United States Code, title 7, subparagraph (c) under section 135 (d), and I quote:

> The examination of chemical poisons or devices shall be made in the United States Department of Agriculture or elsewhere as the Secretary may designate for the purpose of determining from such examination whether they comply with the requirements of section 135—135 (k) of this title, and if it shall appear from any such examination that they fail to comply with the requirements of said sections, the Secretary shall cause notice to be given to the person against whom criminal proceedings are contemplated.

Since the Insecticide Act covers all types of insecticides it seems to me that would cover your flea situation, also.

Mr. STEPHENS. It might. I do not know. I just know what happened in that typhus thing.

Dr. DEARING. Is not that dealing with standards, so that sprays and insecticides shall be up to standard and they shall not sell inefficient or below-standard products?

Mr. BUSBEY. That is in the act. I brought it up because it covers insecticides for all insects, including the fleas that were mentioned.

INCIDENCE OF MALARIA IN UNITED STATES

Now, at the bottom of page 3 of your statement, the last sentence says:

> By this means it is known, for example, that malaria, a disease which was nearly extinct in this country in 1950, was imported by military personnel from Korea in 1951 and 1952 and was transmitted in the United States of America in 1952.

I was under the impression we had testimony before this committee to the effect that malaria had been stamped out in the United States. How much malaria was brought in and transmitted in the United States in 1952, Dr. Andrews?

Dr. ANDREWS. In 1952 through September 27 we had reports of 7,636 cases of military personnel who relapsed with malaria after they returned to this country. Those individuals quite possibly went to all of the 48 States. Of course, the chance of transmission is much less in some States than it is in others, but there has been no great diminution in the number of mosquitoes capable of transmitting malaria; so the stage remains continually set for reactivation and reestablishment of it as long as it is brought in from outside of this country.

I think in 1950, the low point in the history of recent times, at least from the standpoint of malaria, we had a matter of about 2,000 cases reported and, I should add, the majority of those, upon investigation, turned out not to be malaria. We had the problem down that close to extinction, but the military operations naturally reintroduced it. Now, the Army is taking all reasonable precautions they can—the Army, Navy, and Air Force—to prevent that. They have done developmental work; they have subsidized developmental work on antimalarial drugs, some of which work has been done by the National Institutes of Health. Those drugs are being given to the Korean returnees with the hope and expectation that they will be cured so that they will not relapse when they are repatriated. It took some time to get the administrative wrinkles out of that scheme. In about May of this year, one of these drugs, primaquine, was used with reasonable thoroughness, and the number of cases of malaria began to drop off. Now we see from weekly summaries only a few cases each week; whereas before we saw hundreds.

SPECIAL FUND FOR EPIDEMICS

Mr. BUSBEY. The last sentence of your prepared statement reads:

> In spite of the fact that the expenditures for epidemics rarely involve more than travel costs, nearly three-fourths of the funds available have been spent on 15 epidemics in 13 States during the first half of this fiscal year.

Who pays for that personnel, Dr. Andrews?

Dr. ANDREWS. They are regular Public Health Service personnel being paid out of our regular appropriated funds. They are simply taken off of other jobs to use temporarily on this epidemic assistance.

Mr. BUSBEY. And the personnel is paid out of your appropriations then?

Dr. ANDREWS. Yes, sir.

Mr. STEPHENS. If you will look at page 30, that might explain that item, activity 3. It is an item that has been carried for a number of years in this activity that might not be touched, that item of $40,000 for disaster outbreaks here and there which call for immediate action. And when he says three-quarters of the funds available have been spent on 15 epidemics during the first half of this fiscal year, there have been years when it was not used or was not needed to be used. But that specific item has been carried in this appropriation for a number of years for just that sort of outbreaks in the United States as an item to be used for that purpose. It may not be needed but, if something does happen, they draw on that particular item.

It is not authorized for expenditure for general administration or general operations; it is specifically for outbreaks and, if no outbreaks occur, that money reverts to the Treasury. In fact, it is never put back, because it is not taken out. It is carried as an insurance against outbreaks.

Dr. ANDREWS. You may be interested in knowing that much of that was spent in California on the encephalitis outbreak, which involved something like 750 cases of this very serious disease with something like 50 deaths and nearly 300 horse cases. We supplied, at the request of the State health officer, and in 48 hours had 22 Public Health people out there to assist the State in reducing the attack rate of this disease and preventing new cases.

Mr. BUSBEY. Your request for 1954 is $5,735,000?

Dr. ANDREWS. That is correct.

Mr. BUSBEY. That is a reduction of $184,750 from what was actually appropriated in 1953?

Dr. ANDREWS. Yes, sir.

FUNDS REQUESTED OF BUDGET BUREAU

Mr. BUSBEY. What did you ask of the Bureau of the Budget?

Mr. ABBEY. We asked the Bureau of the Budget for $6,506,000.

Mr. BUSBEY. There are no grant funds involved in this item?

Dr. ANDREWS. No, sir.

Mr. BUSBEY. So the reduction is mostly in personal services?

Dr. ANDREWS. That is right.

Mr. BUSBEY. You are reducing the number of positions from 1,242 in fiscal year 1953 to 1,207 in fiscal year 1954?

Mr. ABBEY. That is correct.

REIMBURSEMENTS FROM OTHER SOURCES

Mr. BUSBEY. According to the budget schedule, you show reimbursements from other accounts of $450,000 in 1952, $382,000 in 1953, and you expect $300,000 in 1954. For the benefit of the committee, would you explain briefly, Dr. Andrews, from where those funds come and for what they are used?

Dr. ANDREWS. They come from a variety of sources. We maintain in Atlanta a large motor pool. We have facilities for repairing motor vehicles, and we have contracts with a number of the other Govern-

ment agencies stationed there, such as the Department of Agriculture, the Department of the Army, Civil Defense Administration, Department of Commerce, Interior, State, Navy, Treasury, General Services Administration, and Federal Public Housing Authority. We are able to assist them in repairing vehicles.

We also have some reimbursement for the production of certain audio-visual training aids which we have made for the Army. The most of that has come from the Chemical Corps through Camp Deitrich as well as certain contract research projects which we have done with money supplied by the Army.

Then we produce certain diagnostic materials such as streptococcus typing sera and salmonella typing sera, and for that we receive reimbursement from the Armed Forces and various other places.

That includes the bulk of the reimbursement. We can supply you with a complete list if you wish.

ROUTINE LABORATORY DIAGNOSES PERFORMED FOR STATES AND LOCAL AGENCIES

Mr. BUSBEY. I think that is sufficient.

On page 33 of your justifications, under the heading of "Laboratory Activities," you state that during epidemics State and local laboratories in many cases are taxed beyond their capacities. During 1952 over 56,000 routine laboratory diagnoses to alleviate such situations were performed. Is your department reimbursed from State or local public-health departments for that work?

Dr. ANDREWS. No reimbursements from State or local public-health departments; no, sir.

Mr. BUSBEY. None whatsoever?

Dr. ANDREWS. No, sir.

Mr. BUSBEY. How do these 56,000 diagnoses compare with the previous 5 years?

Dr. ANDREWS. In 1947 it was somewhat over 16,000; in 1950, nearly 38,000; in 1951, about 38,000; in 1952, nearly 65,000; and the estimate for 1953 is around 57,000.

Mr. BUSBEY. When did your department originally start doing this work for State and local public-health departments?

Dr. ANDREWS. It must have been in 1947 and at that time on a very modest scale. It increased during the next 2 years at our special laboratory. You understand this says "routine" here. These activities are routine for us, but they are not routine for State health laboratories. We are doing things which are extra routine for them, which they are unable to do.

If you would be interested, I can supply you with a list of the types of diseases about which we are able to supply diagnostic information. It is something over and above the ordinary run of laboratory diagnostic service for most of the States.

Mr. BUSBEY. How much is this costing your agency?

Mr. ABBEY. We do not have the cost figure on the diagnosis of specimens. Because of the wide variety of specimens, one specimen may cost 20 cents for diagnosis and another may run as high as $200 to diagnose in the case of complex virus diseases.

In addition, this diagnostic work is performed in conjunction with State services—for example, trained State laboratory personnel—and

we perform diagnoses for other parts of the Communicable Disease Center work. All of this is combined in the same laboratories. Trainees, for example, are trained partially by the diagnosis of the specimens submitted from the States. As these are thrown together into one combined operation—and you can visualize it in a large laboratory thrown together—we found it impracticable for that reason and for the varying costs to attempt to establish an accounting-cost analysis of this diagnostic work. It would be very expensive for us to do.

Mr. BUSBEY. I am wondering why the Food and Drug Administration charges for its services in making its tests and analyses while your agency does not.

Mr. HARLOW. It is a matter of law, for one thing, and a matter of preference, I think, for another.

If I may venture a layman's opinion in a cautious manner, one of the primary functions of the Public Health Service as laid down in our act is to cooperate with and assist the States. So that we are a part of the health organization, and just a part of it.

In Food and Drug, I think the philosophy there is that this testing they do is primarily for the benefit of industry; therefore, industry should support it.

I may be completely wrong in that opinion, but it seems to me that must be some of the philosophy in back of the differences between the two organizations.

Mr. STEPHENS. And Food and Drug, under the certification service—of course, that law was passed primarily to provide for testing antibiotics which are produced by the pharmaceutical houses, and, before they can be marketed and labeled, they must be tested; so the certification law which provides for that says they must pay the cost of that. The law provides they shall pay the cost of certification in the certification services and not part of the "Salaries and expenses" item of the Food and Drug Administration.

Mr. HARLOW. Mr. Chairman, the Public Health Service Act authorizes us to detail personnel to other departments of Government on a reimbursable basis. It provides no reimbursement for details to States.

WORK IN CONNECTION WITH FEDERALLY SPONSORED WATER-RESOURCES PROJECTS

Mr. BUSBEY. At the top of page 35 of the justification is this language:

> This item also includes the interagency studies on the Arkansas-Red-White and New York-New England river basins. In addition, it is proposed that studies will continue for preventing the creation of or overcoming health hazards on federally sponsored water-resources projects in the Missouri River Basin, the Pacific Northwest Basin, and the Pacific Southwest Basin.

There is a request for $1,365,000 for water-supply and water-pollution control under the appropriation for engineering, sanitation, and industrial hygiene. What is the difference between these two?

Dr. ANDREWS. We are primarily concerned, Mr. Chairman, with the problem of insect-borne disease, which would be increased by the development of these river basins. We are not concerned with the other engineering attributes, but the work is done jointly on that;

our people work together with the water pollution and other engineering activities on these projects.

Mr. BUSBEY. And in your opinion there is no duplication or overlapping?

Dr. ANDREWS. I think that your question reflects the fact that as this language is written it would seem natural to draw such a conclusion, but a few samples of the actual findings, if you had opportunity to visit the project, I think would enable you to see that they are quite distinct.

EPIDEMIC INTELLIGENCE SERVICES

Mr. BUSBEY. I believe that Dr. Scheele mentioned in his statement, Tuesday, that under the epidemic intelligence services you answered 200 calls from local and State health services last year. I have been thinking about that statement since Dr. Scheele made it, and frankly I find it hard to believe that there were that many outbreaks or threats of real epidemics.

I would like the record to be clear on whether or not these include calls to help in the solution of local health problems?

Dr. ANDREWS. Our idea here is more in the nature of acquiring experience rather than providing an epidemic intelligence service. These young men gain experience in investigating common-source epidemics. We regard this largely as a training period, training and experience for them, after they have had a period of didactic instruction in the investigation of communicable diseases. We assign to States in various regions and fields of research these same men so they can gain by experience the ability to run down these epidemics.

There has been a large number of epidemics and the extent of their importance ranges all the way from such large ones in lower California on down to the lesser important ones. But we never know at the beginning of an epidemic how important it is going to be. The information you have at the outset is that there are 1 or 2 people, or perhaps 3 or 4, with the disease. For example, in the investigations that were made concerning chloramphenicol, a new antibiotic that seemed to have resulted in the development of anemia. The investigation involved a few cases in the beginning, and no one could have foreseen whether it was going to be great or small.

The same thing is true with polio epidemics. You get, perhaps, a rise in the number of cases of poliomyelitis at a particular time, but you cannot tell at that point whether it is going all over the country, or whether it is going to taper off and not be significant. But we must investigate, and the earlier we get the facts from the investigation, the more we can do.

FIELD STAFF AND PERSONNEL IN TRAVEL STATUS

Mr. BUSBEY. How many field offices do you have?

Dr. ANDREWS. Ten.

Mr. BUSBEY. How many people do you have in the station at Atlanta?

Dr. ANDREWS. Roughly 550.

Mr. BUSBEY. And approximately how many of your people travel regularly?

Mr. ABBEY. I think it would approximate about 400. I think we have had 600 to travel at times in the past, during past years, but I think 400 would be about right.

SHELTER FOR CARS AT ATLANTA

Mr. FOGARTY. Dr. Andrews, what happened with respect to your problem of housing the trucks and cars at Atlanta? The reason I ask is that I did not get a chance to get to Atlanta two years ago, but I think Mr. Schwabe and 1 or 2 others have been there, and they made a point of it in the hearings last year. I think we wrote in the report that something should be done.

Dr. ANDREWS. Yes. And it was done. Here is a photograph of the structures which have been provided. Since that time similar installations have been made at Savannah and a comparable number have been built at Montgomery for the same purpose.

Mr. FOGARTY. We have not made any provision for a new laboratory building at Atlanta?

Dr. ANDREWS. No. It was proposed this year, but did not get this far, of course.

Mr. FOGARTY. I think the committee ought to go down there.

Dr. ANDREWS. We would be very glad to have you.

Mr. FOGARTY. I have never been there, and should have gone before.

Mr. STEVENS. Judge McGrath saw them when he was down there last year, I believe.

INTERDEPARTMENTAL PEST COMMITTEE

Mr. FOGARTY. Doctor, to get this clear in my mind, how is this Interdepartmental Pest Committee operating between the 3 agencies: Food and Drug, your people, and the Department of Agriculture? Will you tell us just what is done at a meeting in order to avoid duplication or overlapping?

Dr. ANDREWS. I have not attended meetings recently myself, but the secretary of this committee, Dr. Samuel M. Simmons, who is in charge of our toxicological and insecticidal investigations, is at the meetings, which are attended by representatives of the 3 groups, plus the Armed Forces. There is an agenda, prepared in advance, which programs all special investigations which are to be discussed, so that there is a general diffusion of knowledge and understanding in each of the groups.

In some of the meetings that I have attended, they have made plans for future activities, taking into account special competencies where they exist or where there was an unusual question proposed by someone in attendance, and perhaps even loaned equipment from one group to the other, so that some of these jobs could be done better by people with special competencies in other places. It is a very free, informal meeting. Some of those attending have interests which they realize are closely related. Some of them want to get more information, and to get it with less expenditure of money and time.

Mr. FOGARTY. It is not a question of groping around.

Dr. ANDREWS. No.

Mr. FOGARTY. They know what they are going to do.

Dr. ANDREWS. Yes.

Mr. FOGARTY. Everyone knows what he is working on.

Dr. ANDREWS. Yes, indeed. As I said, a specimen of the proceedings would perhaps be more authoritative than any rambling remarks of mine on the subject.

Mr. FOGARTY. In the Department of Agriculture, when you talk about research, the general thinking is that it is research on plants and animals?

Dr. ANDREWS. That is right.

Mr. FOGARTY. That is what those officials are primarily concerned with, not research on human beings.

Dr. ANDREWS. That is right.

Mr. FOGARTY. But with plants and animals.

Dr. ANDREWS. They are concerned with human beings to the extent that they do not want these materials used which would poison human beings.

Mr. FOGARTY. Of course not.

Dr. ANDREWS. But they do not have the facilities for determining all of these points to the extent that we have.

Mr. FOGARTY. What is the drug that is used now in the control of malaria?

Dr. ANDREWS. Chloroquine.

Mr. FOGARTY. Does the Government make it?

Dr. ANDREWS. No; it is made by the Winthrop Chemical Co.

Mr. FOGARTY. What drug is the Government making? It was making a vaccine of some kind.

Dr. ANDREWS. Yellow fever.

Mr. STEPHENS. That has been discontinued, Mr. Fogarty. We tried to get a pharmaceutical house to take it up soon after it was started. It was made at the behest of the armed services during the war and after 4 or 5 years of effort to get the pharmaceutical people to take it over, the Public Health Service is not manufacturing that vaccine any more.

PROGRESS IN DEVELOPMENT OF INSECTICIDES

Dr. ANDREWS. There is a new development in insecticides, which I think is a very interesting one, and which I think might be of interest to this group, parathion, one of the organic phosphates which has been used with a great deal of success. It is one of the things we are studying now, and from the reports that have been coming into us, it looks very good.

The idea is to use a cord or string and impregnate it with this insecticide. In this illustration the strings are hung from rafters. You see, flies light on these strings; you may have noticed how flies seem to cluster around strings. They have large eyes and, in that way, they can see in both directions. They seek these poison strings, which are hung up out of the reach of children, and there are literally piles of dead flies under each of these cords.

One of the experimental installations we have made has been in certain mess halls of the Armed Forces. We could not hang the strings up over the tables, because the table would just be covered with dead flies. It is very easy, actually, to put these strings at places over containers where they will catch the dead flies.

Mr. FOGARTY. How does it poison; when taken internally?

Dr. ANDREWS. Of course, if taken internally, but it can also be absorbed through the skin.

Mr. FOGARTY. It can be by handling?

Dr. ANDREWS. Yes; it has to be used with great caution. There have been a number of deaths resulting from it, but always when it was not carefully used and not in accordance with the precautions prescribed for handling these poisons.

Mr. FOGARTY. One of the difficulties you have had with these insecticides has been the fact that the insects gradually become immune.

Dr. ANDREWS. That is right.

Mr. FOGARTY. How does that happen?

Dr. ANDREWS. That is what we would like to know. We are spending a good bit of time on it, and as the chairman pointed out, the Department of Agriculture also is facing the same problem. We are making studies of the genetics of resistant and nonresistant flies, of the different attributes of resistance to fly-killing poisons which are passed from one generation to another, and of being able to raise flies which develop more widespread resistance than the flies that have been killed by a particular poison.

For example, when the fly becomes resistant to the DDT type of insecticide, it becomes resistant to all other chemicals which are closely related chemically to DDT.

This parathion, which I have just referred to, so far indicates that it has greater efficiency than other types of insecticides that have been used, and leaves no residue of surviving insects, from which another generation of insects can be produced that is immune to its effect.

Mr. FOGARTY. Human beings become immune to the effect of some drugs.

Dr. ANDREWS. The problem is very similar, biologically, and it is necessary to know the sensitivity of the particular organisms of the insect to this type of antibiotics.

MAJOR OUTBREAKS OF EPIDEMICS IN 1952

Mr. FOGARTY. What were some of the major epidemics in this country in 1952?

POLIOMYELITIS

Dr. ANDREWS. The major one, of course, was poliomyelitis.

Mr. FOGARTY. That was on the increase; was it?

Dr. ANDREWS. Yes.

Mr. FOGARTY. Especially in the Southwest—in Texas.

Dr. ANDREWS. The largest number of cases was reported there and in other parts of the Nation. There was a lot of it in Texas, but it was pretty well diffused throughout the Nation.

SLEEPING SICKNESS

Then we had an encephalitis outbreak.

Mr. FOGARTY. What kind of an outbreak?

Dr. ANDREWS. Encephalitis, sleeping sickness.

Mr. FOGARTY. In that case what did your people do?

Dr. ANDREWS. We sent some people out, veterinarians, entomologists and engineers. This epidemic started primarily because of excessive snows during the winter. The snows in the mountains of southern California suddenly melted and were followed by heavy rains, which provided huge increases in surface water for the developments of mosquitoes. The particular mosquito which transmits this disease is called culex tarsalis, which multiplied at a tremendous scale.

In addition, as a result of the earthquakes in southern California, people were afraid to sleep indoors. They slept outside exposed to mosquitoes, and many of them were bitten by mosquitoes. I am sure they would not have been attacked by mosquitoes had there been no earthquakes.

Those are some of the subtle factors which involve increases in diseases. Our medical men assisted the California public health people working in the hospitals screening admissions for encephalitis. Our veterinarians were looking for cases in horses and for these mosquitoes, to find out if the disease is carried from animals to human beings.

And the entomologists were busy making collections of these insects, and the engineers were doing larviciding and insecticidal work to reduce the number and contacts of these mosquitoes with men.

Mr. FOGARTY. What were some of the others?

Dr. ANDREWS. Hepatitis, in Hickman County, Tenn., a disease that I think we have talked about here before. The disease can be prevented very effectively by use of gamma globulin.

Our people are now in position to help the State and local people in preventing diseases of this kind.

Another one was rabies from foxes.

Another, agranulocytosis in Montana, and in New Mexico, the poliomyelitis outbreak. Another study was made in New Mexico, a central nervous system disease of hogs which seemed to have been related to this outbreak of poliomyelitis. But after a study by the veterinarians and the medical men, they discovered that the two were quite unrelated.

Mr. FOGARTY. What is the name of the disease that people get from drinking milk?

Dr. ANDREWS. "Q" fever.

Mr. FOGARTY. Yes. You were doing some work on that 2 or 3 years ago.

Dr. ANDREWS. Yes; that is going on now, but the work is very nearly completed. I think probably you will see a greater reduction in that this year.

Mr. FOGARTY. It was established that people could get it from contact with cows or milk?

Dr. ANDREWS. Yes, I think it was pretty well established, Mr. Fogarty, that people who drank unpasteurized milk had a much higher incidence of the disease than the people who drank pasteurized milk. And the people who were living in the neighborhood of dairies had a higher incidence rate. It later was shown, experimentally, that this disease could be airborne as well. So there are at least two ways of getting it.

Mr. FOGARTY. How does it affect the person?

Dr. ANDREWS. It is an atypical pneumonia, a pneumonitis. It produces coughing, fever, and respiratory embarrassment.

Mr. FOGARTY. That is all, Mr. Chairman.

EXPLANATION OF AUTOMOTIVE REPAIR SHOP AT ATLANTA

Mr. STEVENS. Mr. Chairman, I would like to ask permission to put in the record this statement, because someone is going to read the hearing and want to know why we are in the automobile-repair business in such a big way, and I would like to explain why.

Mr. BUSBEY. Yes, Mr. Stevens.

Mr. STEVENS. We were more or less up to date on our work when we got this through the Bureau of the Budget making a special study of an overall situation in the United States, checking on the availability of shops owned by Government agencies throughout the United States, and they set about a program to eliminate any duplication of shops, and I think it is sound, in that it is going to eliminate a lot of little repair shops, but they designated one agency only in a community.

For instance, one goes to General Services Administration. We had one. So in order to prevent any duplication by the other Government agencies, we, having the facilities and the supplies, they told us that we could have this for that area, but nobody else could.

I just wanted to get those facts in the record, because someone is going to read the hearings a year from now and find that we have a big automobile repair shop, and that is the explanation for it, and you will find no other shop down there; they send their cars there to get the work done.

Mr. BUSBEY. Thank you, Mr. Stevens.

Mr. STEVENS. Thank you.

Mr. BUSBEY. The hearing will stand adjourned.

THURSDAY, MARCH 26, 1953.

ENGINEERING, SANITATION, AND INDUSTRIAL HYGIENE

WITNESSES

M. D. HOLLIS, DEPUTY CHIEF, BUREAU OF STATE SERVICES
CARL SCHWOB, CHIEF, DIVISION OF WATER POLLUTION CONTROL
VERNON G. MACKENZIE OFFICER IN CHARGE, ENVIRONMENTAL HEALTH CENTER
DR. OTIS L. ANDERSON, CHIEF, BUREAU OF STATE SERVICES
RICHARD SEGGEL, ASSISTANT EXECUTIVE OFFICER, BUREAU OF STATE SERVICES

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$3,752,658	$3,700,000	$3,985,000
Reimbursements from non-Federal sources	1,805		
Reimbursements from other accounts	75,491	93,800	58,000
Total available for obligation	3,829,954	3,793,800	4,043,000
Unobligated balance, estimated savings	−7,778		
Obligations incurred	3,822,176	3,793,800	4,043,000
Comparative transfer to "Assistance to States, general, Public Health Service"	−55,918		
Total obligations	3,766,258	3,793,800	4,043,000

NOTE.—Reimbursements from non-Federal sources above are from the proceeds of sale of personal property (40 U. S. C. 481 (c)).

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
Direct Obligations			
1. Industrial hygiene	$638,839	$644,000	$644,000
2. Environmental research activities	390,437	442,000	620,000
3. Water supply and water-pollution control	1,340,702	1,300,000	1,360,000
4. Radiological health services	360,652	356,000	355,000
5. General sanitation activities	842,310	837,000	885,000
6. Administration	117,827	121,000	121,000
Total direct obligations	3,690,767	3,700,000	3,985,000
Obligations Payable Out of Reimbursements From Other Accounts			
1. Industrial hygiene	12,692	9,800	
2. Environmental research activities	48,900	44,000	44,000
3. Water supply and water-pollution control	8,956	18,000	14,000
5. General sanitation activities	4,943	22,000	
Total obligations payable out of reimbursements from other accounts	75,491	93,800	58,000
Total obligations	3,766,258	3,793,800	4,043,000

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Summary of Personal Services			
Total number of permanent positions	610	608	646
Full-time equivalent of all other positions	6	6	5
Average number of all employees	550	563	605
Average salaries and grades:			
General schedule grades:			
Average salary	$4,629	$4,742	$4,748
Average grade	GS-6.7	GS-6.8	GS-6.9
Crafts, protective, and custodial grades:			
Average salary	$3,075	$3,023	$3,061
Average grade	CPC-4.5	CPC-4.8	CPC-4.8
Ungraded positions: Average salary	$14,000	$14,000	$14,000
Personal service obligations:			
Permanent positions	$2,899,960	$3,087,820	$3,278,100
Part-time and temporary positions	37,742	39,100	33,900
Regular pay in excess of 52-week base	7,032	7,370	7,900
Payment above basic rates	660	1,100	1,600
Total personal service obligations	2,945,394	3,135,390	3,321,500
Direct Obligations			
01 Personal services	2,900,238	3,060,360	3,271,000
02 Travel	233,607	221,250	233,950
03 Transportation of things	37,764	23,150	25,900
04 Communication services	27,672	25,500	28,800
05 Rents and utility services	40,108	31,600	36,200
06 Printing and reproduction	112,128	112,150	121,600
07 Other contractual services	61,658	48,250	64,800
Services performed by other agencies	40,000	20,000	20,000
08 Supplies and materials	120,797	97,650	100,900
09 Equipment	108,774	54,000	74,600
12 Pensions, annuities, and insurance claims	2,394		
13 Refunds, awards, and indemnities	248		
15 Taxes and assessments	5,379	6,090	7,250
Total direct obligations	3,690,767	3,700,000	3,985,000
Obligations Payable Out of Reimbursements From Other Accounts			
01 Personal services	45,156	75,030	50,500
02 Travel	8,827	12,840	4,000
04 Communication services	155	370	
08 Supplies and materials	2,248	2,760	2,000
09 Equipment	19,092	2,800	1,500
15 Taxes and assessments	13		
Total obligations payable out of reimbursements from other accounts	75,491	93,800	58,000
Total obligations	3,766,258	3,793,800	4,043,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$454, 842	$336, 432	$351, 432
Obligations incurred during the year	3, 822, 176	3, 793, 800	4, 043, 000
	4, 277, 018	4, 130, 232	4, 394, 432
Deduct:			
Reimbursable obligations	77, 296	93, 800	58, 000
Adjustment in obligations of prior years	15, 368		
Unliquidated obligations, end of year	336, 432	351, 432	391, 432
Total expenditures	3, 847, 922	3, 685, 000	3, 945, 000
Expenditures are distributed as follows:			
Out of current authorizations	3, 433, 064	3, 405, 000	3, 665, 000
Out of prior authorizations	414, 858	280, 000	280, 000

Mr. BUSBEY. The committee will come to order.

The committee has before it for consideration the appropriation request for fiscal year 1954 for "Engineering, sanitation, and industrial hygiene, Public Health Service."

I believe you have a general statement you would like to make, Mr. Hollis.

Mr. HOLLIS. Yes.

GENERAL STATEMENT

Mr. Chairman, and members of the committee, this appropriation provides for four broad programs in the field of sanitary engineering and industrial hygiene. I should like to explain the fundamental considerations that govern all these activities.

Wholesome air, water, food, and shelter are essential to health and thus problems of sanitation are common to all people. These problems become more and more complex as our civilization advances, as our cities and industries grow.

Our record in sanitary-engineering practices, over the past 30 years, is one of close teamwork among Federal, State, and local operations. The pattern of this association is as simple as it is effective. Primary authority and responsibility for operations and regulatory actions in sanitation rest with the State and local governments. The greater part of community sanitary control is paid for and carried out at the county or municipal levels. Federal functions are to carry out research and investigations on national problems for which effective controls are not known; to handle problems interstate in character—problems beyond the jurisdiction of individual States; and, finally, to back up the States on health problems that are beyond their individual resources and facilities.

To illustrate how this pattern operates, I can cite a simple example. In the twenties there were repeated widespread epidemics of typhoid fever and other enteric diseases traced to contaminated shellfish and milk. In response to appeals from States and the desperate shellfish industry, the Congress in 1925 appropriated funds for the Public Health Service to work out practical methods of control that could be applied by the States. By 1930 we had a staff of some 60 people working in close collaboration with the 23 shellfish-producing States. Our research produced practical sanitary standards, and techniques to safeguard the shellfish-producing areas, the processing establishments, and interstate shipments. The Public Health Service assisted

the States in installing the necessary control measures, and, in collaboration with all States, worked out and administered an interstate certification program.

Today, shellfish move freely in interstate traffic. It is a multimillion-dollar industry. Shipments by dealers certified on the Public Health Service list are accepted by health authorities in all States and cities of the Nation. State and local health agencies in the producing areas spend about a million dollars per year to assure the safety of this easily contaminated food. The Public Health Service estimate to carry out its part of the national shellfish program for fiscal year 1954 is in this appropriation. It is less that $50,000. At its peak it was almost 10 times as much.

The experience with the national milk program is similar. This most nearly perfect food is also easily contaminated. By 1930, we had established the basic requirements for safe handling of milk from the dairy barn through processing and distribution, including the control of pasteurization. Jointly with the States and industry, after extensive study and investigation, the first edition of the Public Health Service Standard Milk Ordinance and Code was developed and published in 1927. The long job of organizing and establishing local milk-control programs was under way. Today, our citizens take for granted the intricate network of sanitary protection behind the delivery of the safe bottle of milk at the door. Again as the State and local control pattern evolved, the Public Health Service withdrew to what we consider our proper role: research and study of new technical developments; keeping the Standard Milk Ordinance and Code current with such developments; helping the States to cope with changing technical problems; and working with the dairy industry on specifications for the sanitary design of milk processing equipment. The estimate of $140,000 to carry forward this program is included in this appropriation.

Obviously, much more dramatic and more involved has been our work in the early development of safe public water supplies and sewage systems. Our research during the first three decades of this century has served as the basis for sanitary water and sewage practice since that time.

In the field of food, our cooperative efforts with States have been largely responsible for this country's high standards of food sanitation. But, as with water and wastes, revolutionary changes are taking place in the food industry. It is on these changes that our major effort is now placed.

We are now barely beginning to realize the impact on health of the byproducts of this great modern technology. I would emphasize that we are without precedent as to the effects on health of industrial fumes in the air, chemical wastes in our streams, more chemicals in our foods, and in general our evolving synthetic environment. The introduction into the environment of radiation is another example of an influence destined to affect us all. In sanitary engineering we are undergoing a transition from the bacterial stage to the virus and chemical stage.

RESEARCH

Our living environment has in fact changed so fast that there are large gaps in our knowledge as to how to adjust to it. Our greatest single need, therefore, is for better understanding—knowledge that comes from research—largely, applied research. The Congress recognized this need when it authorized and appropriated funds for the construction of our new Research Center at Cincinnati. This laboratory is now about ready for occupancy. With this new facility we can begin to attack some of the highly complex problems I have mentioned. In addition, we hope to improve current methods of sanitary control with particular emphasis on reducing their cost.

For example, the new membrane filter not only promises dramatic reduction in time for necessary bacterial examination but indicates a major reduction in the present $25 million expenditure for such services. For the first time this filter was used—and quite successfully—in the sanitary controls of the water supply serving "Pullman City" here in the District of Columbia during the recent inauguration.

Another recent development at Cincinnati is a practical method to extract and concentrate the exotic chemicals in our drinking-water supplies from 50,000 gallons or more of water to a few cubic centimeters. When standardized this promises to be a most useful tool in our modern water-supply technology.

Likewise, increasing concentrations of human sewage are further endangering our sources of water supply. We are particularly concerned about this in terms of the virus diseases. Our research plans include studies on the survival of selected viruses.

With respect to sewage-treatment research, emphasis will be toward development methods of physical separation to replace much more costly biological stabilization. Such a development will permit reclaiming for beneficial use the valuable fractions present in sewage. The time is approaching when we can no longer afford to throw these away.

The pollution of the atmosphere, with its impact on health, is only beginning to be felt. The events in Los Angeles, Donora, Detroit, and the 2,000 deaths in London this winter, merely highlight a condition that is growing in significance in every city.

So far research has done little more than to collect and identify a few of the contaminants in the atmosphere. The next step is to learn how to measure quantitatively their presence and full effects.

When our Cincinnati Center is in full operation it will serve as the technical resource and laboratory research arm for our sanitary engineering programs.

WATER SUPPLY AND WATER POLLUTION CONTROL

In the field of operations, the problem of water supply and water pollution control is of the utmost importance to the health as well as the economy of this country. Traditionally, we have been concerned with water supply in relation to the control of communicable diseases. The addition of much greater quantities of human sewage coupled with the discharge of huge volumes of industrial wastes into our streams places an almost overwhelming burden on our water-treatment facilities. Under these and similar circumstances the water-

works profession has been doing a remarkable job over the Nation. I might cite one example of the difficulty they are facing.

In 1950, a survey by six States fronting on the Ohio River revealed dramatic evidence of the foul conditions caused by human and industrial wastes. At only 3 of the 27 sampling stations along a stretch of almost 1,000 miles was the bacterial quality within the range considered acceptable for public water supply purposes. Yet 2 million people are dependent upon that source of supply for their drinking water. On some of the tributaries the conditions are even worse.

In the next 25 years our industrial and public water supply requirements are expected to double. This tremendous demand will be leveled against essentially a fixed water supply. The answer lies in two major approaches: (1) Storing our great flood flows and releasing them throughout the year to better distribute our fixed supply and (2) cleaning our water through sewage and industrial waste treatment so that it can be reused again and again. Our water pollution control program is intimately concerned with the health aspects of both of these approaches. If this job is done properly, we protect also industrial, agricultural, and recreational uses of our waters.

We must keep in mind that water pollution is a national problem—a problem involving responsibilities at both State and Federal levels. Clearly recognized are the primary rights of the States. We are working with the States to encourage the enactment of uniform State laws.

But laws and regulations of either the States or the Federal Government will not alone solve the pollution problem. The utilization of our water resources and the abatement of pollution is so complex and involves so many interests that it cannot be approached successfully except on a total watershed basis. In most cases this means an interstate basis. More than half of the 226 river basins in the Nation are interstate in character in that their waters cross or form the boundary between two or more States. Our work to date has identified 108 areas in which interstate pollution is significant. Correction of this pollution lies beyond the authority of the receiving States.

Our program is confined to activities generally beyond the jurisdiction or resources of the individual States and may be divided into five major areas:

1. Research to develop improved methods for the measurement of pollution and the evaluation of toxicity; and, more rapid and less costly methods of treatment.

2. Participation in interagency committees to insure the provision in water resource developments of plans for safe public water supplies and reasonable pollution control.

3. Cooperation with industry to develop waste-treatment methods, and abatement programs to be carried out by industry. This activity is carried on mainly through the National Technical Task Committee on Industrial Wastes representing all major segments of the Nation's industries.

4. Technical assistance to State pollution control agencies on problems interstate in character.

5. Enforcement of pollution abatement as specified by law. This phase of the program is just emerging.

In facing the national water pollution problem we must keep in mind the economics involved. Correction of pollution will involve an

expenditure by industry and public agencies, largely cities of between $9 billion and $12 billion based on 1950 costs. It must be considered a legitimate expense and part of the price we must pay for our highly developed industrial economy and concentrated urban development.

RADIOLOGICAL HEALTH PROGRAM

Our radiological health program is a typical approach to a new problem in which health authorities generally are as yet inexperienced. Broader development and increasing uses of radioactive materials will impose additional responsibilities on the States. Health departments have expressed their concern on this matter and are using the limited resources and facilities of the Public Health Service in establishing and developing their own machinery to deal with the impact on health of this new force.

The efforts of the Public Health Service in this field are designed to help the States to meet their responsibilities in the emerging atomic age.

Liaison relationships with the Atomic Energy Commission and Department of Defense provide a coordinated approach. This liaison relationship also makes possible the fullest utilization of information developed by these agencies for health protection programs of State and local levels.

INDUSTRIAL HYGIENE

Over the past quarter century, our work in the field of industrial hygiene has led to the elimination of many major health hazards in industry. Also, it has contributed significantly to the development of sound industrial health programs in our larger industries.

Our services to industry and the workers are rendered by research, clinical and environmental investigations and technical aid to the States. Also, we are working closely with the Council on Industrial Health of the American Medical Association in fostering the development of in-plant health services. The chief objective is to assist industry in solving its problems.

The major field investigations now underway include studies of health hazards associated with the mining and milling of uranium, the refining of shale oil, and the mining and processing of diatomaceous earth.

Research is being conducted continuously to identify the more hazardous and toxic industrial compounds and agents, their effects on the health of workers, and methods of control. One of the results of this research is to provide information for use by industry and also for use by the States in the establishment of standards or "maximum allowable concentrations" for hazardous materials. Our work also includes research studies in the health effects of abnormal temperatures, humidities, and pressures; excessive noise and vibration, inadequate and improper illumination; and radiant energy.

We are also conducting research in the field of industrial dermatoses, which head the list of compensable occupational diseases. This research is directed toward the determination of the basic causes of skin allergy and the development of ways and means of eliminating or

reducing the amount of contact between the many industrial irritants and the skin.

GENERAL SANITATION

Our operations in the field of general sanitation are included in this estimate. This item covers milk and food and shellfish activities; the interstate quarantine program of carrier sanitation, home accident prevention studies, the investigation of basic sanitation facilities, and the sanitary disposal of garbage and refuse. These programs are all undergoing a transition. They are being adjusted to cope with the complex health problems attending widespread technological changes.

The only increase for general sanitation activities is for trichinosis control, a parasitic disease conveyed to man from swine that have been fed uncooked garbage. This feeding practice is responsible also for several livestock diseases, including hog cholera and vesicular exanthema. The latter disease has recently brought severe economic losses to American farmers. The Department of Agriculture and several livestock groups have requested our assistance on the health aspect of this problem. The funds requested will enable the service to provide cooperative assistance through the enforcement of our regulations against interstate shipment of raw garbage.

In the field of milk and food, in addition to the many scientific and technical problems confronting us, we have found it necessary to initiate, at the request of the States, a voluntary program for certification of interstate shipments of milk. Both health and economic benefits are derived from this program.

This summarizes, Mr. Chairman, the activities provided for under this appropriation. I shall be glad to attempt to answer such questions as the committee may wish to make.

X-RAY WORK

Mr. BUSBEY. Mr. Hollis, referring to page 8 of your prepared statement, under the heading "Radiological health," will you tell us what you do in connection with X-rays?

Mr. HOLLIS. Under this program no special work on X-rays. We do advise on radiation protective measures in some of our own hospitals. We do work on problems that are incidental, such as in connection with X-ray shoe-fitting machines where States and municipalities want advice on safeguards of such matters. We do advise in those areas.

We do not check in the field of X-ray in terms of therapy or treatment.

COOPERATION IN INDUSTRIAL HYGIENE WORK WITH BUREAU OF LABOR STANDARDS

Mr. BUSBEY. Where does your work described on the following page under the head of "Industrial hygiene" differ from that of the Bureau of Labor Standards in the Department of Labor. Is there any cooperation between the two agencies?

Mr. HOLLIS. Yes, sir. We do have a very close liaison with the Department of Labor in this effort. The broad line of delineation is that the Department of Labor has the responsibility, full responsi-

bility, on safety measures in industry, and efforts related to accident prevention. This is a clear-cut line. We have a clear-cut responsibility in the understanding with the Department of Labor in fields of research, particularly medical research and research into the toxic conditions and the health hazards of industrial practice.

Where the two programs tend to get very close together is in methods of controlling hazards, because the enforcement provisions, the legal enforcement provisions are generally in the Department of Labor. In this area we work very closely with them, so as to avoid any misunderstanding or overlapping.

But in the two extremes, which are the bulk of the respective functions, there is a very clear delineation.

Mr. BUSBEY. Have there been situations where you have made a determination in a survey, and then presented that determination to the Bureau of Labor Standards to put into effect?

Mr. HOLLIS. Yes. As a matter of fact, we have no enforcement authority at all, that is, Federal; we turn our findings in written reports over to the proper State authorities, and of course over to the Department of Labor.

COOPERATION WITH DEPARTMENT OF AGRICULTURE IN VESICULAR EXANTHEMA CONTROL

Mr. BUSBEY. This situation with respect to hog diseases interests me considerably, because my district is close to the stockyards out in Chicago where they have had considerable trouble with this disease. What is it called?

Mr. HOLLIS. VE—vesicular exanthema.

Mr. BUSBEY. That is handled by the Department of Agriculture, is it not?

Mr. HOLLIS. By and large, yes; because it is an economic problem, and in terms of that disease, not a health problem. We are brought into it at the request of the Department of Agriculture for this reason: Fundamentally, Mr. Chairman, we have, under our interstate quarantine regulations authority to prevent the interstate shipment of raw garbage. That particular regulation was put through in an effort to curb the increased incidence of trichinosis in the country. The Department of Agriculture was without that particular authority, so they asked us to cooperate with them in the effort to control and prevent this situation with respect to hogs.

Another point developed, after we got into it, which, while minor, is of some significance. In a discussion of the matter with a State veterinarian who has authority for the VE control in Alabama, he said that he had sufficient control in intrastate problems to deal with city garbage, and through his efforts he made a list of maybe 4 to 10 restaurants and hotels that were contributing raw garbage to be fed to hogs. In checking with some local health departments he found that whereas he had maybe 10 or 12, there were many more involved. He appealed to the State health department for assistance of local health officials and other agencies to handle that one disease, that is, means to prevent VE by this method, results in the control of trichinosis, which is very definitely a health problem.

Mr. BUSBEY. Where does the Division of Communicable Diseases get into this problem; are they in this program some place?

Mr. HOLLIS. Not in this particular control. We are working through our regional office structure, employing the interstate quarantine regulation which is administered by this means.

Mr. BUSBEY. How is the control on VE coming along now?

Mr. HOLLIS. Perhaps the most authoritative statement is in a recent issue of the Farm Journal, which indicates that there has been some reduction, but by no means a sharp reduction in the incidence of the disease. It is hoped that there will be within the next year very vigorous efforts made to attack the problem at its source. In other words to prevent raw garbage being fed to hogs.

RELATIONSHIP TO DIVISION OF COMMUNICABLE DISEASES IN TRICHINOSIS CONTROL WORK

Mr. BUSBEY. I was looking at the justification for the Division of Communicable Diseases, at page 33 of the justification, and in the fourth paragraph trichinosis is mentioned as one of the items for which that Division is asking funds.

Mr. HOLLIS. It is listed with other diseases in terms of consultation; and in terms of an epidemic outbreak. Administratively in the Public Health Service everything relating to epidemiological services is in one place, at the Communicable Disease Center. Our effort to control and enforce the interstate quarantine regulations relating to garbage crossing State lines, is carried out through our regional office structure.

Mr. BUSBEY. First of all, it says—

The estimate provides for continuance of consultative, investigative, and demonstrational services.

That is in the justifications under the subject head of "Field Studies on Diseases," under Communicable Disease Control.

Mr. HOLLIS. Even so, the language is not entirely clear for the demonstrational, in terms of epidemiology of these diseases, certainly, in terms of trichinosis it is.

FURTHER DISCUSSION OF RELATIONSHIP TO DEPARTMENT OF AGRICULTURE

Mr. BUSBEY. In your justification where you speak of VE control, it says—

The Department of Agriculture and several other groups have requested our assistance on health aspects of this problem.

If this is a problem of the Department of Agriculture, why does not the Department of Agriculture handle it?

Mr. HOLLIS. Actually, Mr. Chairman, the bulk of the work is done by the Department of Agriculture. What we do in this and all we propose to do is to aid the Department of Agriculture by aiding in our relations with the State and local health department structure. We work through our regional offices to maintain, as the chairman knows, a close relationship with the States, as indicated in the Alabama experience. The State and local health departments, as a byproduct effort of their existing staff, can be of real assistance. Our proposal is to add one man to the regional office in those areas where the problem is highly significant to work cooperatively with the States and with the Department of Agriculture in getting the groups together.

The only significant point is that the existing authority to control the shipment of garbage across State lines is in the interstate quarantine regulations of the Public Health Service. This authority is not in terms of VE control, it is in terms of trichinosis. Our work in this area is because of our interest in trichinosis, which is a health problem.

Mr. HARLOW. May I add a further explanation to what Mr. Hollis has said, that when this budget was proposed to the Bureau of the Budget, sitting in on the discussions were the people in the Bureau of the Budget, those handling the Agriculture estimate, and those handling the Public Health estimate; they all participated in the discussion—representatives from the Public Health, the Department of Agriculture, and the Budget. They asked us to get in, as Mr. Hollis has indicated, because we are the agency which has the authority to prevent the interstate shipment of raw garbage across State lines, and presumably they are working through the States to handle the intrastate angle of it.

I cannot conceive of a budget that was better coordinated than this one.

Dr. DEARING. One of the byproducts in which the Department of Agriculture is interested is livestock, and one of the items there is the trichinosis problem.

Mr. BUSBEY. While this does not come within the purview of your agency, I wonder if by any chance you happen to know whether there is any provision in the new budget for the Department of Agriculture to make 100 percent restoration to the farmers or hog raisers that have losses resulting from this disease?

Mr. HOLLIS. I do not know the answer to the question. I have some information concerning partial indemnity, but I am not versed enough on it to know what is provided for in the next fiscal year.

INTERSTATE SHIPMENT OF GARBAGE

Mr. BUSBEY. Is there a great deal of garbage shipped interstate?

Mr. HOLLIS. Not as much, Mr. Chairman, as we thought when we first got into this program. There are in isolated areas, some huge interstate shipments, but they are not as widespread as you might imagine. We found that perhaps instead of thousands of problems of interstate shipments like this, that it will be more nearly in hundreds. There is no such shipment that it would be impracticable to handle.

Mr. BUSBEY. In other words, it would be just a small percentage?

Mr. HOLLIS. Yes.

Mr. BUSBEY. What is the recommendation at the consumer level for handling this problem? Can something be done with reference to the cooking of pork?

Mr. HOLLIS. Where pork is properly cooked, the disease is prevented as heat destroys the trichinosis worm.

Our problem is the handling of other pork byproducts; the difficulty comes in the trimmings, the bacon rinds, and the pork rinds, and the ham trimmings that are generally thrown into the garbage. These are sufficient to contaminate the garbage, and that has been the difficulty in the problem of trichinosis control. It appears from the prac-

tical standpoint that we have to pasteurize or cook the garbage before it is used as hog feed.

Mr. BUSBEY. Mr. Hollis, your request for fiscal year 1954 is for $3,985,000?

Mr. HOLLIS. That is correct, sir.

Mr. BUSBEY. And that provides for an increase of $285,000 and 40 additional positions?

Mr. HOLLIS. Yes, sir.

PROPOSED INCREASE IN PERSONNEL FOR ENVIRONMENTAL HEALTH CENTER

Mr. BUSBEY. On page 44 of the justifications, under "Environmental research activities," you have the increase broken down into several categories.

The first one is for personal services. What is the reason for the increase of 22 positions?

Mr. HOLLIS. That, Mr. Chairman, is for the positions we propose to fill in connection with the occupancy of our new research center at Cincinnati, the Environmental Health Center. As to the details of the positions, with your permission, I would like Mr. MacKenzie who is director of the center, to break it down in whatever detail you might wish.

Mr. BUSBEY. That is perfectly all right.

Mr. MACKENZIE. The details of that increase in personal services is shown on page 46 of the tabulation. The increase is broken down into two categories: First, those that are required for additional scientific competence in relation to the research program which is proposed; second, the additional people, custodial in nature, required in connection with the operation and maintenance of the new building.

You may note that the breakdown calls for 12 additional people in scientific categories and 10 additional in the custodial categories. I might add at this point, however, that we have planned, in connection with the operation of this building, to use the so-called custodial people not only for maintenance of the building but also for certain supporting services which are needed in relation to the research program. The electrician, for instance, is needed to maintain the electrical facilities in the building but is also required to service the electric types of equipment which are used by the scientific people in the laboratories.

Mr. BUSBEY. On just what kind of work do you propose to use those 12 additional scientific men?

Mr. MACKENZIE. On a variety of projects. For instance, the one which is tabulated here as a full-grade surgeon is scheduled to be used on the study of viruses, particularly in relation to problems of water purification as related to virus contamination, the studies that are proposed in relation to viruses related essentially to the ability of current water purification processes either to remove or to inactivate them. We have information indicating that the water-purification practices as normally carried on by municipalities are not delivering effective or inactivating such agents.

For instance, with respect to the chlorination of water, which is the standard procedure for its disinfection, preliminary experiments have indicated that the level of chlorination which is required for inactiva-

tion of virus agents is considerably higher than that which is routinely practiced for killing vegetative bacteria itself.

The second in line, senior assistant grade scientist, is also scheduled for viruses.

The senior assistant grade sanitarian is scheduled for studies on aerobiological contamination. That is contamination of the air by micro-organisms.

The GS–13 chemist is scheduled for the project of development of physical implementation which is highly desirable in order to improve the current practices of sanitation and effect economies and further improve the effectiveness of procedures which are carried on.

The chemist, GS–12, is intended for a study of the kinetics of chemical reactions in order that we may understand more fully what happens to contaminated chemical substances, their discharge to the water or air, and the procedure which will be necessary either to remove or inactivate them. We know, for instance, that materials discharged into water are affected by biological life in the water and persist in the water for varying lengths of time and have a lot of the characteristics of the chemical substance involved. The knowledge is highly important in respect to the expenditure of funds which is necessary to control the adverse effect which may, for instance, have some time relationship downstream in a river, for instance, from the point from which the contamination is introduced.

The chemist, GS–11, is intended for similar studies.

The GS–7 bacteriologist is scheduled for a project which is mentioned, I believe, in the justification, on a reappraisal of methods of water treatment which are either currently in process or available for use by municipalities and water companies. Much change in the art of water purification has occurred over the last 25 years since there was last made a comprehensive review of this particular subject. It is necessary, in our opinion, that such a comprehensive review be made at the present time in order to bring the processes up to date with respect to all of the scientific information which may be available.

The GS–7 chemist is scheduled for the same project as is one of the GS–5 aids which are listed. The other GS–5 aid is scheduled for the virus study which I have mentioned.

The statistician, GS–7, is scheduled to give general support across the board in our statistical services to the scientific staff at the center.

Mr. BUSBEY. Are these new positions for which you are asking funds going to be used on new work, or are they for the purpose of expanding the amount of work on existing projects?

Mr. MACKENZIE. It is both. Some of those are for expansion and some are new. The water-treatment project, for instance, is a new one. Currently we are not carrying on any pilot-plant work in relation to water treatment. We do not have any extensive survey work going on in the field there.

With respect to the appraisal of practices as currently carried on by municipalities, we have done a small amount of pilot study in the field of viruses—sufficient, I am sure, to indicate that there is needed a real expansion of the studies in that regard.

RIVER BASIN SURVEY WORK

Mr. BUSBEY. The last full paragraph on page 48 of the justifications states:

> Under authority of the Flood Control Act of 1950 (Public Law 516, 81st Cong.), comprehensive plans for the integrated development of water and related land resources are currently being made by those Federal agencies, including the Public Health Service, primarily interested in such resources. One study covers the drainage basins of the Arkansas, White, and Red Rivers, and another New England and upper New York. The States in these two regions are cooperating in this work which must be completed by June 30, 1954. Completion of these reports by this deadline will require an increase of $51,500 during 1954.

That does not seem to agree with the contents of a letter dated January 7 and corrected as of January 19 from the Director of the Bureau of the Budget to Mr. Taber, chairman of the Appropriations Committee, because this letter of January 7 addressed to Chairman Taber starts out:

> Continuing our regular practice, I am writing to set forth certain information which I hope will help you and the Committee on Appropriations in your consideration of the 1954 budget.

Then the last paragraph deals with these two surveys and says:

> The Arkansas-White-Red River Basin survey and the New England-New York survey have heretofore been financed by appropriations of the various participating agencies, and it is proposed to continue this practice in 1954. However, in order to facilitate uniform consideration of the agency budgets involved so that a balanced program will result, there is attached a table showing the amounts included in the estimates for these surveys (attachment C). The target date for the completion of the surveys is June 30, 1954, and the financing proposed in the budget is on that basis.

Along with the letter of January 19, the Budget Bureau sent a revised attachment C as of January 15, 1953, in which it listed the various agencies which are provided for in the budget. I have not seen any provision for the Public Health Service in that attachment C.

Now, I was wondering why the Public Health Service was not mentioned in that letter from the Bureau of the Budget.

Mr. HOLLIS. I must confess, first, I do not know why we are not included. The Federal Security Agency, Public Health Service, has been named in the official designation of Federal agencies to work on those two basin reports, and in the submission of our estimates to the Bureau of the Budget we decided to submit that part of the estimate that dealt with water pollution and public water supply under our normal estimates covering that subject. That part of our work that dealt with the control of insects on impoundments is under the appropriation "Control of communicable diseases." We felt that would keep like things together in our estimates. That explains why the witness this morning in presenting the communicable-disease appropriation commented on his part of these estimates, and this part of the estimate is under the water-supply and water-pollution control. And I am at a loss to explain the Bureau of the Budget communication.

Mr. BUSBEY. Well, there is the schedule, and there is nothing in it for the Public Health Service, either for your Division or for the Communicable Disease Control Division that I understand is also doing some work in this area.

Mr. HOLLIS. Of course, these estimates were reviewed by the Bureau of the Budget, and it was clearly stated in the record of the review what the intended use was.

Mr. HARLOW. Mr. Chairman, we have been active in these surveys ever since they started. I think it is just an oversight on the part of the Budget Bureau, myself.

Mr. SEGGEL. I might say we were specifically advised that part of the increase was for these surveys in accordance with the schedule set forth in there.

Mr. BUSBEY. Just to clear up the matter, maybe it would be well for you to secure a short explanation for the record at this point, because it is a little confusing to see that you are not listed in this table which is clearly headed "Funds proposed in the 1954 budget" and which includes two agencies that have less funds in total requested for their work than the increase requested in your budget.

Mr. HOLLIS. We will do that.

(The information requested is as follows:)

The Bureau of the Budget advises that the letter dated January 9, 1953, from the Director of the Bureau of the Budget to Mr. Taber, chairman of the Appropriations Committee, referred only to those agencies which had separate appropriations, or separate appropriation language limitations, with respect to the Arkansas-White-Red and the upper New York-New England surveys. The estimates for Public Health Service work on these surveys are an integral part of its total estimates for water pollution control activities and for communicable disease control activities, and are not set forth as separate appropriation items. We are further advised that certain other participating agencies are not mentioned in the Bureau of the Budget letter for the same reason.

Dr. DEARING. I should like to make clear that the communicable disease appropriation has nothing to do with the water pollution control authority as such. It is under our general charge in that division to study and be aware of all disease problems. The simple reason they are working on the Arkansas-Red-White and New England-New York basins is that certain communicable disease problems relate to the problems going on there and, as I understand, it is on insect control problems which spread disease created by impoundment.

Mr. HOLLIS. I might add that in the administration in the basin program, the personnel of CDC are attached to and work under the direction of our basin office; so it is not independent at all. It is budgeted independently in an effort to keep the record of the operations clear.

APPROPRIATIONS FOR BASIN SURVEY WORK

Mr. BUSBEY. I notice that you say the work on these surveys will require an increase of $51,500 for 1954. How much was spent in 1953?

Mr. HOLLIS. With your permission, I would like to have Mr. Schwob answer that. He is Chief of the Division of Water Pollution Control.

Mr. SCHWOB. In 1953, in the New England-New York basin, we spent $71,300 and, in the Arkansas-White-Red, we spent $82,400.

Mr. BUSBEY. You want an increase of $51,500 over that?

Mr. SCHWOB. Yes, sir; to finish the work that needs to be completed by June 30, 1954.

Mr. STEPHENS. Mr. Chairman, I have this to offer on that subject of these two basins. Public Health, these people, work in a lot of

basins. Those are two of them. The Bureau of the Budget in this joint note that was mentioned, of October 19, concluded that at least these two basins ought to be wound up and finished by June 1954, and they told me over the telephone that the increase allowed in this budget was specifically to conclude the studies in those two areas and have the reports completed. They had apparently a joint meeting of minds between Defense, Reclamation, Public Health, Interior, and a number of others, and we were told that was what the specific allowance was for.

DELAY IN OCCUPANCY OF ENVIRONMENTAL HEALTH CENTER

Mr. BUSBEY. Now, on page 505 of last year's hearings, I believe you stated, Mr. Hollis, that the Cincinnati building would be ready for occupancy early in fiscal year 1953.

Mr. HOLLIS. I did, sir.

Mr. BUSBEY. It is now well past the middle of fiscal year 1953. Are you in the building at the present time?

Mr. HOLLIS. We are not yet. The date given us early last year was a target date of October or November 1952 for completion of the building. There were certain delays on materials, we were told. Unfortunately, there was a fire during construction, which delayed completion, and there have been other delays that have interfered with the completion of the building. However, it is now practically complete, and it is my understanding as of yesterday with Public Buildings that within the next few weeks it can be turned over to the Government by the contractor for final inspection by PBS, and then, of course, they will turn it over to us.

Mr. BUSBEY. The longer you delay getting into the building, the more it is costing in the form of rent. Did the delay in drawing up the specifications and letting bids for the equipment have anything to do with the delay?

Mr. HOLLIS. Not in the completion of the building. Construction contracts, as you know, had been let all together. The specifications for the equipment to go in the building now have been completed; contracts have been let, and the equipment will be moved in on a coordinated schedule. We are going to move the new equipment in with all of the equipment we now have simultaneously so as to avoid loss of time of our research people.

LETTING OF CONTRACT FOR EQUIPMENT

Mr. BUSBEY. When were the contracts let for the equipment of the building?

Mr. MACKENZIE. The main contract for equipment was let early this month by the Public Buildings Service.

Mr. BUSBEY. Why was that held up until this month?

Mr. MACKENZIE. The Public Buildings Service has advised us it was a complicated job and required the preparation of several hundred drawings. Frankly, it is something I think we cannot answer in full detail—your specific question. We have confidence, however, with respect to the ability of the Public Buildings Service to deliver us a satisfactory final job. We are much pleased with the quality of the work that is incorporated in the building as it now stands.

Mr. BUSBEY. When did they start working on those numerous drawings you spoke of?

Mr. MACKENZIE. We turned the matter over to them with respect to the equipment drawings in a period which started about March of last year and was completed by about the middle of June 1952.

Mr. BUSBEY. If the building had been completed then, you could not have moved in, anyway, without the equipment; could you?

Mr. MACKENZIE. No, sir.

Mr. BUSBEY. It just seems to me that the letting of those contracts for the equipment should have taken place long before this month. What assurance do you have that the equipment will be ready when you get ready to move in the building?

Mr. MACKENZIE. Our schedule for moving in the building necessarily will have to be coordinated with the work of the contractor on the equipment, because under his contract he is required to fabricate the new equipment, deliver it to the building, and install it; at the same time, he has an obligation to install the equipment which we are now using in our existing laboratories, in the new location, in the new building, and tie that in with the new equipment which he is furnishing.

Mr. BUSBEY. You expect to be in the new building on what date?

Mr. MACKENZIE. We will move in gradually, according to our present estimates, starting about late May and running through July and August, I would expect, as the equipment contractor delivers the materials on the job.

Mr. HOLLIS. I might add that the first move will be out of rented buildings with the last move out of the building that we are occupying now that belongs to the city, and I think the city has agreed to that. Have they not?

Mr. MACKENZIE. The city is perfectly agreeable to whatever schedule suits our operation needs there.

PROGRESS OF CONSTRUCTION OF BUILDING

Mr. BUSBEY. The building itself will be to the point of completion so that you could start moving in at what date?

Mr. MACKENZIE. The contractor has advised us that he will complete the principal construction contract in approximately 3 weeks. Now, that, of course, is entirely up to whether or not he finishes the remaining work which has to be done, which is principally completion of the painting and some of the interior finish work. Thereafter there is some additional work under the small contracts let by the Public Buildings Service, the principal item of which is the installation of asphalt tile flooring in the lower areas.

Mr. HOLLIS. A point on your question, Mr. Chairman, is that the building contract is under the control of the Public Buildings Service; and until the contractor turns a building over to the Public Buildings Service and they accept it in the name of the Government and turn it over to us, we are without authority in the matter.

Mr. BUSBEY. I think we should have for the record a statement by the Public Buildings Service as to the cause of the delay in the completion of the building, and also an explanation of why the contract for equipment was not let until this month.

(The information requested follows:)

MARCH 27, 1953.

STATEMENT OF PUBLIC BUILDINGS SERVICE CONCERNING THE CONSTRUCTION AND EQUIPPING OF THE PUBLIC HEALTH SERVICE ENVIRONMENTAL HEALTH CENTER BUILDING, CINCINNATI, OHIO

The planning of this project, from inception in 1938 to final authorization in 1948, was subject to considerable delay and revision, finally resulting in appropriations totaling $4,000,000 for the planning and construction of the Environmental Health Center Building at Cincinnati, Ohio. A contract for the construction of the building was awarded on December 18, 1950, with a completion date scheduled as of October 18, 1952.

During the course of construction, the contractor encountered numerous unforeseeable and unavoidable delays in obtaining permits from the city, obtaining essential materials because of governmental controls then in force, and because of strikes and a fire. The building, exclusive of equipment, is now substantially completed. Final inspection is scheduled for the month of April 1953.

Funds for the purchase and installation of the necessary laboratory equipment were made available in the Labor-Federal Security Appropriation Act, 1953, approved July 5, 1952. The Public Buildings Service is prohibited by law from entering into contracts which would bind the Government to pay a larger sum of money than the amount in the Treasury appropriated for the specific purpose.

Promptly after the necessary funds were appropriated on July 5, 1952, the Public Buildings Service undertook to prepare the drawings and specifications necessary to obtain the equipment required. It had available to it such information as had been previously received from the Public Health Service, which information has been subsequently supplemented, revised, and adjusted to meet the needs and conditions revealed as precise requirements could be refined.

In order to advertise the work it was necessary to prepare 394 drawings together with contract specifications and bidding documents. All of this work was completed between July 5, 1952, and January 5, 1953, an interval of 126 working days. On January 9, 1953, competitive bids were requested for the furnishing and installation of new equipment and for the relocation and reinstallation of existing equipment. These bids were opened on February 8, 1953.

The Director, Bureau of the Budget, on February 3, 1953, directed the suspension and a reappraisal of all construction projects and related work. The Federal Security Agency advised the Public Buildings Service on February 26, 1953, that this reappraisal had been made and that there was adequate justification to warrant completion of the work and the award of the equipment contract. This contract was awarded on March 17, 1953, with 180 calendar days for its completion.

It is appropriate to record that the installation of the equipment could not proceed until the construction contractor had completed the interior finish on the building. The presently effective schedule provides that concurrently with, or shortly after the construction contractor has completed his work, the equipment contractor will start delivery and installation of the laboratory equipment.

The relocating of existing laboratory equipment and the furnishing of new equipment supplemental thereto requires careful planning and close collaboration between the equipment contractor and the Public Health Service. We have every assurance that this cooperation will be forthcoming so that the building may be put to its intended use without undue delay beyond presently scheduled dates.

W. E. REYNOLDS,
Commissioner of Public Buildings.

DIVISIONAL UNITS WHICH ARE TO OCCUPY SPACE IN BUILDING

Mr. BUSBEY. Who is going to occupy the building?

Mr. HOLLIS. It is proposed, Mr. Chairman, to move all of our environmental health operations, in Cincinnati, in the building.

As we analyze the space situation in the building, there will be on the fourth floor some nine-thousand-odd square feet of space that is in excess of the immediate needs.

In the determination of the use of that space, we are considering the possibility of moving in at least certain elements of the industrial

hygiene laboratory which are located in Cincinnati. Certainly some of this work would lend itself to the type of space we will have available.

Also, we have in mind and are considering the possibility of consolidating in Cincinnati some of the closely related operations that are not now located in that city with the view that this would make for a closer coordination and for a tighter operational program. The space that will be available, unfortunately, is insufficient to take all of the industrial-hygiene laboratory. It may be that we will consolidate some of the activities elsewhere in Cincinnati in the additional space, but that decision has not as yet been made.

AREA IN NEW BUILDING

Mr. BUSBEY. How many square feet of space are there in the building?

Mr. MACKENZIE. Immediately upon occupancy of the building available to us will be 84,600 square feet of usable space. This compares to a figure of 53,400 square feet net usable space in the quarters, which the environmental health center currently occupies in Cincinnati.

Mr. BUSBEY. You anticipate moving only a part of the industrial hygiene personnel into the building?

Mr. HOLLIS. That is correct.

Mr. BUSBEY. Why can all of it not be moved into the building?

ANALYSIS OF AREA

Mr. HOLLIS. May we analyze the square-footage area, Mr. Chairman, which I think will clear up the question.

Mr. MACKENZIE. I would like to explain, Mr. Chairman, the use of the space for which I have given you the figures. The office space and type of laboratory for the environmental health center will not be increased in the new building over the 2,900 square feet now in the building.

Mr. BUSBEY. That is in addition to the 53,000 you are using?

Mr. MACKENZIE. No, sir. Currently in the 53,400 square feet we are including the laboratory and the office space, principally. We have a small amount of space for library and a portion which I would include in that total.

Now, of the office space and laboratory, which we currently operate, we will have available in the new building about 2,900 square feet additional area in that same type of space.

I am sure you will appreciate that the wide scope of the program included in the research-activity centers require not only a wide competence of scientists, but requires also a specialized type of facilities for carrying on the work. Some of those we have lacked. And in the major expansion of space in the new building, which relates to providing that type of new facilities, the additional space is required for our program.

For example, we currently have practically nothing in the way of animal experimental facilities; and in the new building are provided 3,100 square feet for that purpose. In the rented quarters which we have at the present time we do not have any type of adequate develop-

ment-shop area, which is essential for the support of scientific work. The new building will provide 8,300 square feet of area for that purpose.

Our pilot plant and experiment area is carrying on work which will bridge the gap between that which is carried on in the laboratory generally and in actual practice in the field. Currently it is very inadequate, and the new building will provide 12,100 square feet for carrying on that type of activity.

Similar expansions have been made in the physics laboratory and for carrying on work in the field of toxicology, and they will get 3,800 square feet. In addition to the isolated location—at least isolated with respect to restaurant facilities, in the buiding layout we included a small cafeteria, and 1,800 square feet have been provided in the building for that purpose.

The net usable space figures which I have given you also include an allowance of 8,400 square feet for maintenance facilities, principally, the heating boilers, ventilation equipment, pumps, and compressors, for compressed air, and so on.

Mr. BUSBEY. Getting back to the original point of usable space, which you said was 84,600 square feet, how much will be used by the environmental health service?

Mr. MACKENZIE. All of it.

Mr. BUSBEY. If you are going to use it all, where can you put the industrial hygiene laboratory? I understood you to say that a part of that was going to be moved in.

Mr. HOLLIS. What I intended, Mr. Chairman, to say was in addition to this 84,600 square feet, on the fourth floor of the building there are approximately 9,000 square feet as yet not completely finished. The contingency fund was insufficient to complete this space. However, it can be used for certain types of operation.

That gives us an additional 9,000 square feet that can be used by certain adjustments, by moving certain things on the lower floors up to the fourth floor, and thereby make available some 9,000 feet of area for the occupational health laboratory. Or, if we do not use it for that we would use it by moving into Cincinnati some of the closely related operations of the environmental health center in the interest of better administrative programs.

Mr. BUSBEY. I take it this 84,600 square feet is net usable area, and does not take into consideration the corridors.

Mr. HOLLIS. That is correct.

Mr. BUSBEY. And other sections of the building not used.

Mr. HOLLIS. That is correct.

GROSS AREA OF BUILDING

Mr. BUSBEY. What is the total square footage, including everything?

Mr. MACKENZIE. The gross area in the building amounts to about 135,000 square feet.

Mr. BUSBEY. How much square footage does the industrial hygiene center occupy now?

Mr. HOLLIS. It is somewhere between 30,000 and 40,000 square feet—close to 30,000 square feet, Mr. Chairman.

Mr. BUSBEY. The bulk of this environmental health center work and of the industrial hygiene center work are located in the same building at the present time?

Mr. HOLLIS. No. A segment of the environmental health center, principally the office, the training facilities, and a section of the biological laboratory are in the same building with the occupational health laboratory. But the chemistry, engineering and radiological research are in a separate building at Third and Kilgore Streets.

COMMON USE OF EQUIPMENT

Mr. BUSBEY. These two divisions work together in a great many projects, do they not?

Mr. HOLLIS. In terms of programs they are not too closely related, Mr. Chairman.

Mr. BUSBEY. For instance you hold classes for State, local and industrial health specialists, and they work together in this instruction program don't they?

Mr. HOLLIS. Yes.

Mr. BUSBEY. And there is a certain amount of equipment that you use in common, I believe.

Mr. MACKENZIE. May I explain that we carry on at various health centers training courses for State and local health personnel, principally. When we are carrying on these courses related to occupational health and industrial hygiene obviously it is, I think, desirable that we enlist the support and assistance of the specialists in those particular fields, that are located with us in Cincinnati and in the other divisions.

Similarly, if we are carrying on work closely related to water pollution control, we might augment the training staff which we have used in carrying on the training, by specialists either from some other part of our program or elsewhere in the Public Health Service as may be desirable.

We do share equipment, and it is obvious, and I think efficient and to the advantage of the Government that where two divisions are working in close proximity, that the equipment should be used to the best advantage by both, insofar as it can be arranged on a program basis.

Mr. BUSBEY. I agree with you thoroughly, and it was for that reason that I cannot understand why the industrial health center will not be put into the same building with the environmental health center.

Mr. HOLLIS. Mr. Chairman, if it can be worked out, obviously we would like to do it. We cannot see at the moment that there will be enough space in the new building for both operations.

There is another factor, however, that I think we have to consider. Some of this building, under the original authorization, was designed for certain purposes as provided in the act, and that was done incidentally before it was thought that the industrial health laboratory would be located at Cincinnait.

Some adjustments would have to be made for industrial hygiene operations. For example, in the animal experiment work, the chambers used for experimental animals are bulky pieces of equipment, requiring certain types of foundation, and exhaust apparatus.

It will require considerable adjustments for them. But it is not impossible to so do, and we are hoping when we get into the building to get a clearer picture of space possibilities. Certainly we will consider the facts which you have mentioned.

Mr. BUSBEY. When was the determination made, and by whom was it made, not to include the industrial health center in this building?

Mr. HOLLIS. Mr. Chairman, when the building was designed, shortly after the passage of the act, the industrial hygiene laboratory was not in Cincinnati. Subsequently, when the industrial hygiene laboratory was moved——

Mr. BUSBEY. When was it moved to Cincinnati?

Mr. HOLLIS. In 1950 and 1951.

Mr. BUSBEY. That was before the building was started?

Mr. MACKENZIE. It was about January 1951 that the contract was awarded on the building.

Mr. HOLLIS. At that time the total space available, Mr. Chairman—may I, at this point, make one other point that I started to make a while ago?

Mr. BUSBEY. Certainly.

ORIGINAL DESIGN OF BUILDING

Mr. HOLLIS. The building as originally designed called for 7 floors, and it was designed in terms of foundation support for 7 floors.

However, the appropriation authorization and the appropriation for construction did not permit that much building, so 2 floors had to be left off, so now we have a building with 5 floors.

Had we got the total building, we then proposed to utilize the two top floors for the industrial hygiene occupancy. As a matter of fact, we had this in mind when there was a shift of the industrial hygiene laboratory to that area. When it became obvious that we would not have enough funds to complete the building as originally designed, the design used was such as to meet the needs of the environmental health center. Actually it will do that, and at the moment that is about what it will do, in terms of total footage.

Mr. BUSBEY. But you say the original plans were drawn to include the industrial health center in the building?

Mr. HOLLIS. It was our decision that this be done. Also if it should be determined to construct a building on the adjoining land that has been acquired, the industrial hygiene laboratory at that time would become part of the operating unit.

We certainly recognize the desirability of getting them together.

Mr. BUSBEY. I think it is generally recognized that it is far more expensive to add to a building after it has been completed than it is to construct the extra floors when the building is under construction.

Mr. HOLLIS. That is true.

Mr. BUSBEY. Was the elimination of the top two floors due to the increased cost of the building?

Mr. HOLLIS. Yes. The estimate on the building, the figures that were used in the hearing, when Public Law 845 was passed, as given by the Public Buildings Service was $5 million to do the total job.

That was at the time when construction costs were on the downward trend, and the total authorization in the act was $4 million.

Mr. BUSBEY. The total authorization was $4 million. Is that what was spent in constructing the building?

Mr. HOLLIS. Yes, including the drawings, specifications, and related expenditures.

Mr. BUSBEY. Did anyone ever come back to the Congress and explain the predicament and try to get an increased authorization to cover the increased cost of construction?

Mr. HOLLIS. It was mentioned to the Bureau of the Budget, but to my knowledge, not brought officially to the Congress.

Mr. BUSBEY. Would you say that the reason that the seven floors were not built was due to action of the Bureau of the Budget?

Mr. HOLLIS. No.

Mr. BUSBEY. I am trying to find out who is responsible for this situation we find ourselves in. Somebody is responsible, either your agency, the Bureau of the Budget, or the Congress. I would be just as critical of Congress if it were at fault as I would be of some other agency.

Mr. HOLLIS. Mr. Chairman, the act as passed, as I am sure you recall, was to construct and equip a building for use in connection with the water-pollution program, public water supply, and related work. I can only offer that as a possible explanation for it.

Mr. BUSBEY. Yes but you just said a moment ago that it included the industrial health center.

Mr. HOLLIS. If we had gotten the seven floors, we would have put the industrial health laboratory in that building; yes.

DISADVANTAGES OF SEPARATE HOUSING FOR INDUSTRIAL AND ENVIRONMENTAL HEALTH UNITS

Mr. BUSBEY. Were the environmental health center and the industrial health center in the same building, you could have, of course, the common use of equipment. You could also continue any other common activities such as classes for State, municipal, and industrial health specialists.

How far is the building you are now occupying from the new building?

Mr. HOLLIS. It is about 5 to 6 miles, Mr. Chairman. But may I add that of course the use of the common training facilities will continue.

Mr. BUSBEY. But it is certainly not going to be as convenient or economical if the 2 units are 5 or 6 miles apart as it would be if they were located right in the same building.

Mr. HOLLIS. That is true.

Mr. MACKENZIE. We are confronted with exactly the same situation, however, Mr. Chairman, in that the chemistry laboratory and the milk and food laboratory are in different locations in Cincinnati. We are operating currently in three different locations. We will experience some improvement; we will be operating in 2 rather than 3 buildings.

Mr. BUSBEY. I know, but the whole idea of this building, as I understand it, was to get all of these activities together in one central

location to promote efficiency and economy. Does not the industrial health center do work similar to that done by the environmental health center, especially in the field of radiological and air-pollution work?

Mr. HOLLIS. No. All of the air-pollution work is in the environmental health center. The industrial hygiene laboratory is not in that field. In the field of radiological health, the work as stated in that area is under the environmental health center. The industrial hygiene operations are in an area within the industry itself.

RENTAL COST FOR INDUSTRIAL HEALTH CENTER

Mr. BUSBEY. How much rent does the industrial health center pay at the present time?

Mr. MACKENZIE. That is on obligation carried by the Public Buildings Service, Mr. Chairman; it is not carried in the Public Health Service budget.

Mr. BUSBEY. Do you happen to know what the figure is?

Mr. MACKENZIE. As I remember the figure, I would say that the lease was negotiated at $36,500 a year.

Mr. STEPHENS. We will check the record and put the correct figure in, Mr. Chairman.

(The information requested is as follows:)

The Public Buildings Service advises that the cost for 1952 for rent was $30,000 and for maintenance was $7,345.

Mr. SEGGEL. May I state, Mr. Chairman, that in 1950, after the Korean war had started and before this construction was started, the President ordered a resurvey of all public works needs, including those for which funds had been appropriated, and a considerable amount of money was impounded. No doubt that had the effect of discouraging the attempt by anyone to suggest an increase in amount for the building, when there was a possibility that the building might be taken out altogether.

EXPLANATION OF BUILDING COSTS

Mr. BUSBEY. What was the estimate of the cost of the building as originally planned, including all seven floors?

Mr. MACKENZIE. I do not have that figure.

Mr. BUSBEY. Will you supply it for the record?

Mr. HOLLIS. Yes, or an explanation of it.

(The information requested follows:)

CONSTRUCTION OF PUBLIC HEALTH SERVICE RESEARCH FACILITY AT CINCINNATI, OHIO

The Public Health Service research laboratory for water supply, pollution abatement, and associated purposes was established in Cincinnati, Ohio, in 1913, in an old Government-owned residence, located at East Third and Kilgore Streets, previously used as a Marine Hospital. In the past 15 years additional responsibilities assigned to the laboratory required the acquisition of rental space in several widely scattered locations.

The Congress in 1938 authorized a new laboratory facility and subsequently appropriated funds for the initial structure. The war emergency, however, canceled out this plan.

In February 1948 Representative Charles Elston, Ohio, introduced H. R. 5329, a bill calling for the construction of a research building. The 80th Congress considered this proposal along with several other related water pollution-control

bills. Senate bill 418, as amended, introduced jointly by Messrs. Taft and Barkley, received favorable consideration by the Congress. Upon signature by the President on June 30, 1948, the measure became Public Law 845, the Water Pollution Control Act. Section 8 (b) of this act stipulates:

"There is hereby authorized to be appropriated to the Federal Works Agency for each of the 5 fiscal years during the period beginning July 1, 1948, and ending June 30, 1953, a sum not to exceed $800,000 to enable the Federal Works Administrator to erect and to furnish and to equip such buildings and facilities at Cincinnati, Ohio, as may be necessary for the use of the Public Health Service in connection with the research and study of water pollution and the training of personnel in work related to the control of water pollution. The amount authorized for this purpose shall include the cost of preparation of drawings and specifications, supervision of construction, and other administrative expenses incident to the work: *Provided*, That the Federal Works Agency shall prepare the plans and specincations, make all necessary contracts and supervise construction. Sums appropriated pursuant to this authorization shall remain available until expended."

The Congress appropriated, for fiscal year 1949, $200,000 to be expended by the Federal Works Agency for the preparation of plans and specifications for the structure. The specific appropriation language stated:

"Buildings and facilities, Cincinnati, Ohio: For preparation of plans for buildings and facilities at Cincinnati, Ohio, for the use of the Public Health Service, as provided for by S. 418, 80th Congress, $200,000, to remain available until expended: *Provided*, That this paragraph shall be effective only upon the enactment into law of S. 418, 80th Congress" (Public Law 785, 80th Cong., 2d sess.).

The balance of the $4 million was appropriated during the fiscal years 1951 and 1952. For the year 1951, $1,400,000 was appropriated as follows:

"Buildings and facilities, Cincinnati, Ohio: For completion of construction of buildings and facilities at Cincinnati, Ohio, for the use of the Public Health Service, as authorized by section 8 (b) of the act of June 30, 1948 (Public Law 845), $1,400,000, to remain available until expended, and in addition thereto the General Services Administration is authorized to enter into contracts for such purposes in an amount not exceeding $2,400,000" (Public Law 759, 81st Cong.).

For the fiscal year 1952, an appropriation was made as follows:

"Buildings and facilities, Cincinnati, Ohio: For payment of obligations incurred pursuant to authority granted under the head 'Buildings and facilities, Cincinnati, Ohio,' General Services Administration, in the Independent Offices Appropriation Act, 1951, $2,400,000, to remain available until expended" (Public Law 134, 82d Cong.).

In 1947, original plans called for erection of a building of approximately 160,000 square feet gross area, comprising 6 floors, a basement, and a subbasement, and requiring an estimated expenditure of $5 million, computed on a construction cost of $30.74 per square foot.

The Water Pollution Control Act, passed June 30, 1948, contained a total authorization for this building of $4 million and the subsequent appropriations passed were for this amount. However, building construction costs had increased 20 percent by the fall of 1950 over 1947, and the cost of constructing the original $5 million building was, therefore, now $6 million, as compared to the authorized and appropriated amount of $4 million. Accordingly, the Service had to either modify the original plans, or seek statutory authority for additional appropriations (there being no escalator clause in either the authorization or the appropriation).

In the meantime, as a consequence of the Korean war, the President, in a directive dated July 21, 1950, to all executive agencies of the Government, requested them "* * * to conduct a detailed review of Government programs, for the purpose of modifying them wherever practicable to lessen the demand upon services, commodities, raw materials, manpower, and facilities which are in competition with those needed for national defense. The Government, as well as the public, must exercise great restraint in the use of those goods and services which are needed for our increased defense efforts."

During the fall of 1950, formal hearings were conducted by the Bureau of the Budget as to whether the construction of the buildings would be allowed to proceed or the funds impounded. This research building was finally determined to be an important contribution to essential defense and civilian requirements, and the Budget Bureau agreed to permit construction to begin. In view

of the defense situation and the President's directive, it seemed best to modify the original plans to stay within the $4 million ceiling established by the Congress.

During this period, plans were formulated to shift the industrial hygiene laboratory from Washington to Cincinnati. This move was completed by June 1951. The original (1947) plans had not included provision for housing this laboratory.

At the present time, the existing building can be enlarged by two additional floors, the foundation structures having been designed to provide for such expansion. The additional floors would increase the gross area by 35,000 square feet, and the net area 21,000 square feet, and would provide for present needs of the industrial hygiene laboratories. The land owned by the Government at the new building totals 24 acres. Ample space is thus available for an additional structure in lieu of two additional floors should this consideration prove the more economical.

Mr. BUSBEY. Personally I think this is very important work, and it is very important that these two groups be together under one roof. Certainly some attempt should have been made to have the Congress authorize enough money to put these two divisions in one building.

SCIENTIFIC EQUIPMENT

Would you compile a list for the record of the scientific equipment you have in Cincinnati, including each item the original cost of which exceeded $200?

Mr. MACKENZIE. Yes, that can be done.

Mr. BUSBEY. Then will you have that list prepared and inserted in the record at this point?

Mr. MACKENZIE. Yes. May I inquire as to the specific type of equipment you are interested in? Is it the movable type of equipment? For instance, I am referring to a laboratory bench type, which is used in the building.

Mr. MACKENZIE. You are referring to scientific equipment.

Mr. MACKENZIE. You are referring to scientific equipment.

Mr. BUSBEY. Yes. And I think that information should be broken down as between the industrial health center equipment and the environmental health center equipment.

(The information requested follows:)

Environmental Health Center

	Total cost
Bacteriology laboratories:	
Balance, analytical (2)	$749.44
Centrifuge (2)	997.90
Deepfreeze	218.84
Dishwashing machine	575.00
Electrophoresis apparatus	1,825.00
Glass cutting machine	250.00
Incubator:	
Isotropic	275.00
35°–70°	575.00
37° (water jacketed)	250.00
Magnetostriction oscillator	1,865.35
Microphotometer, light scattering and indicating recording	1,995.00
Microscope:	
Monocular	300.00
Binocular (2)	650.00
Wide field, stereoscopic	426.00
Shaker, flask, rotary action	355.00
Spectrophotometer	585.00

Environmental Health Center—Continued

	Total cost
Bacteriology laboratories—Continued	
Sterilizing oven, hot air, electric	$1,800.00
Strip chart, recorder	630.00
Ultracentrifuge:	
Analytical, refrigerated	15,800.00
Preparative	5,205.00
Water bath, constant temperature	295.00
Biology laboratories:	
Autoclave (sterilizer) gas heated	520.00
Balance, analytical	350.00
Centrifuge	350.00
Conductivity apparatus, audio oscillator	475.00
Cooling unit, portable	470.00
Filter (carbon water filter)	289.00
Hydrogen, ion meter	225.00
Microscope:	
Binocular, stereoscopic	447.50
Phase	1,307.00
Microscope:	
Binocular (9)	2,697.00
Monocular (2)	450.00
Spectrophotometer	225.00
Still, water	270.00
Engineering Surveys and Investigations:	
Balance, analytical (7)	2,600.00
Balance	227.00
Counter, proportional flow	385.00
Flow measuring apparatus	970.00
Gas supply apparatus	355.00
Hydrogen, ion meter (2)	490.00
Incubator:	
Compressor unit (4)	1,000.00
Refrigerator (2)	500.00
20°–37° (2)	2,350.00
Water jacket (2)	600.00
37° (10)	2,950.00
Meter, current (3)	715.00
Microscope (2)	500.00
Microscope:	
Binocular	485.00
Medical	497.00
Stereoscopic	443.50
Oven, drying	355.00
Pump	276.98
Recorder:	
Continuous chart	312.55
Water level (3)	753.00
Shaking machine, laboratory	215.00
Spectrophotometer (2)	1,237.50
Still, water (4)	1,033.40
Milk and food laboratory:	
Autoclave (sterilizer) electric	400.00
Balance, analytical	275.00
Centrifuge	350.00
Drying oven 35°–180° C	350.00
Freezer	322.25
Freezing and drying equipment	650.00
Hydrogen, ion meter	245.00
Incubator:	
Isotropic 32°–70°	450.00
37°	300.00
Microscope:	
Binocular (3)	1,076.00
Monocular	275.00
Low power	336.00

Environmental Health Center—Continued

	Total cost
Milk and food laboratory—Continued	
Micro-sample mill	$310.00
Recording hygrometer	645.00
Refractometer (3)	985.00
Spectrophotometer	335.00
Sterilizer, steam pressure	410.00
Table, hot food, electric	496.16
Tensiometer, interfacial	302.50
Titrator, automatic	650.00
Viscometer, electro	525.00
Water bath, refrigerated	910.00
Chemistry laboratories:	
Balance, analytical (7)	2,337.20
Bath, constant temperature, refrigerated	640.00
Centrifuge (3)	750.00
Centrifuge, angle	210.00
Colorimeter, photoelectric	436.50
Counter:	
Flow, preflush	289.00
Methane, flow	375.00
Proportional, converter	385.00
Current recorder	310.00
De-ionizer	350.00
Densitometer (2)	683.00
Filter	493.37
Glass cutting machine	270.00
Incubator, 37°	250.00
Incubator, high temperature	500.00
Microscope (3)	920.00
Muffle furnace (2)	748.00
Oscilloscope, cathode ray	857.19
Photometer	475.00
Potentiometer (3)	675.00
Projector	257.50
Proportional Counter (3)	1,088.00
Refractometer	650.00
Scaler:	
Counter (3)	762.80
Parallel plate for alpha counting (2)	1,237.22
Scaler, preset count	603.56
Scaling unit	395.00
Scaling unit, proportional and scintillation counting (2)	1,055.94
Scintillation counters, alpha, beta, gamma (2)	778.00
Shield, lead (3)	653.96
Spectrograph	400.00
Spectrophotometer:	
Various models (5)	3,920.00
Infrared, recording, double beam	11,895.00
Still, water (3)	979.00
Survey meter, portable radiation (3)	805.00
Titrator:	
Automatic (2)	1,479.96
Amperometric	227.50
Tube checker	204.05
Warburg apparatus	425.00
Radiological training laboratory and demonstration rooms:	
Analyzer, capacitor	500.00
Balance, analytical	310.00
Counter, proportional, alpha	275.00
Densitometer	213.75
Generator, electric	624.00
Hydrogen, ion meter	220.00
Incubator (2)	1,416.00
Ionization chamber	350.00

Environmental Health Center—Continued

	Total cost
Radiological training laboratory and demonstration rooms—Continued	
Meter:	
Counting rate	$353.00
Condenser—r	595.00
Geiger tube	250.00
Ionization chamber survey	276.49
Radiation survey, portable (14)	3,595.64
Survey, beta-gamma (13)	3,155.00
Survey, alpha, beta, gamma (2)	590.00
Megohmmeter	520.00
Monitoring instrument (2)	544.26
Monitors, meter count rate, alpha (3)	1,475.88
Oscillograph, cathode ray (2)	578.00
Proportional counter converter	385.00
Radiac sets (12)	2,565.00
Radium container	1,137.50
Ratemeter	742.50
Recorder (2)	508.00
Scaler:	
Alpha counter	954.93
Battery operated (2)	1,150.00
Decimal, various types (5)	3,227.00
Circuit	600.00
Scaling unit, beta-gamma (4)	2,859.18
Scintillation probe (2)	848.20
Shield, lead (11)	2,836.00
Shoe fitter, X-ray	595.00
Tube checker	201.14
Voltage divider	270.00
Sanitation training laboratory and demonstration rooms:	
Balance, analytical	350.00
Balopticon, automatic	360.00
Microscope:	
Stereoscopic (4)	1,503.64
Binocular (3)	1,266.00
Ocular	345.50
Microprojector	324.00
Polarograph	390.00
Spectrophotometer	652.50
Titrator, amperometric	228.00
General station equipment:	
Air compressor (4)	1,388.91
Air sampler, electrostatic	275.00
Autoclave (sterilizer) gas heated (2)	895.00
Camera:	
Graphic	241.44
Motion picture	800.00
35mm and 4 x 5	397.50
Contrifuge, electric	315.00
Meter:	
Air	252.00
Wet test, air	282.70
Microscope, electron	7,500.00
Ultrasonorator	2,500.00
Spectrograph, emission	17,858.00

Industrial Health Laboratory

Chemical analytical laboratory:	
Laboratory oven, drying	$240.00
Electric furnace, Lindberg model G–10	1,500.00
Pyrometer furnace control	200.00
Spectrophotometer, Beckman model DU 2, at $1,100	2,200.00
Spectrophotometer, Coleman model 10S	350.00
Flame photometer, Beckman No. 350	750.00
Polarograph, Sargent No. XXI	1,500.00
Polarizing microscope, Spencer	750.00
Abbé refractometer	425.00
Wide field microscope, Spencer	320.00
Analytical balance, projection, Christian Becker	450.00
Analytical balance, semimicro, Christian Becker	235.00
Roller particle size analyzer	400.00
Boran carbide mortar and pestle	300.00
GE–XRD1 X-ray diffraction unit	4,500.00
Speedomax recorder	1,000.00
Leeds & Northrup microphotometer	4,500.00
Electroanalyzer, Fisher	375.00
Constant temperature bath, American Instrument Co	350.00
Physical analytical laboratory:	
Perkin Elmer Model 21 recording infrared spectrophotometer complete	16,970.00
RCA electron microscope	18,500.00
RCA shadow casting unit for Electron miscroscope	1,000.00
Bausch and Lomb Large Littrow Spectrograph, complete	7,000.00
Hilger medium spectrograph	3,500.00
Jarrell-Ash model 200 nonrecording Comparator, densitometer	3,200.00
Ainsworth balance, analytical, type TC	500.00
American Instrument Co. drying oven	600.00
Motor generator set, 250 volts, complete	850.00
Refrigerator, 6 cubic feet	200.00
Muffle furnaces, complete with pyrometer controls, 2 at $400	800.00
Roller-Smith balance	250.00
Water still, Barnstead, electric	200.00
Air conditioning unit, electron microscope room	200.00
Hilger interferometer	1,000.00
Biochemical laboratory:	
Spectrophotometer, Coleman Universal, model 11	340.00
Centrifuge, International size 2	370.00
Barcroft-Warburg apparatus, 14 manometer model	435.00
Balance, Ainsworth, analytical type TC, carrier	375.00
Engineering laboratory:	
Mercury vapor tester	800.00
Electrostatic fume sampler (old model)	275.00
Electrostatic fume sampler (new model)	500.00
Alnor velometer, 6, at $202	1,212.00
Benzol indicator	225.00
Carbon monoxide indicators, 8 at $300	2,400.00
Sound level meter	320.00
Constant percentage band sound analyzer	400.00
Octave band sound analyzer	619.00
Wet gas meter	375.00
Rotameter	483.00
Millamometer recorder	419.00
Voland analytical balance	240.00
Homelite electrical generator	485.00
Microscopes, B. & L., 3, at $375	1,125.00
Dust chamber, ¼ inch stainless steel	4,500.00
Nash high vacuum pump	300.00
Refractometer	250.00
Camera, 4 by 5 speed graphic	225.00
Camera, Kodak, medalist	304.00
Lathe, South Bend	700.00
Saw, table	270.00
Shear, squaring, 36 inch	260.00

Industrial Health Laboratory—Continued

	Total cost
Radiation laboratory:	
Scaler	$400.00
Proportional counter converter	350.00
G. M. survey meter, MX–5	200.00
"Cutie-Pie" survey meter, SU–1B	300.00
"Samson" alpha survey meter, D–3	325.00
Laboratory monitor, SU–3B	275.00
Condenser-r-meter	600.00
Refrigerated water bath	600.00
Clinical laboratory:	
Auto technicon	600.00
Centrifuge	315.00
Colorimeter, Klett	215.00
Refrigerator, GE	245.00
Microtome	315.00
Microscope, 2 at $350	700.00
Analytical balance, Christian Becker	375.00
X-ray unit, Picker	2,500.00
Incubator	350.00
Respirometer, Collins	750.00

COMPARISON OF ENVIRONMENTAL AND INDUSTRIAL HEALTH WORK

Mr. FERNANDEZ. What is the difference between the environmental health and industrial health centers?

Mr. HOLLIS. We usually refer to the environmental health center as covering all of the work in the sanitation and engineering field, relating to air, water, food, and shelter.

The field of industrial hygiene, as the name applies, relates to conditions within industry; conditions of production and processing. Industrial hygiene covers work within the industrial plant—conditions in mines or in other industrial areas.

The only real difference is in terms of the area covered.

Mr. FERNANDEZ. With respect to the industrial health center, why does industry not do that work, or arrange to have it done?

Mr. HOLLIS. Actually, industry is doing much research. Our work, in terms of industrial problems, is an industrial hygiene program, and is limited to a few of the national and regional problems in a particular type of industry, where they are interested to know the effects of the different industrial processes on health. A classical example is silicosis in the coal mines.

Mr. BUSBEY. Industry itself is very much interested in knowing the effect on its employees; is it not?

Mr. HOLLIS. Yes, all of the corrective measures are instituted by industry. Research, investigations, and compilation of basic data on which control procedures are based is our work.

Mr. BUSBEY. I am intrigued by these two bottles which you have on the table before you. I know you did not bring these bottles here without wishing to say something about them. Would someone like to comment on the contents of these bottles in connection with your work?

Mr. HOLLIS. I would like to if I may, Mr. Chairman.

The increased use of chemicals has caused us to wonder what the impact is on our environment and hence on our health.

For example, with the huge volume of industrial waste going into streams, including chemical pollution, how much of these chemicals, and what type, go through normal water-treatment processes? We actually had no means of measuring this load, although we know that there must be a considerable quantity. This concern has led to the development of a carbon filter which can be inserted in the water system. By using this activated carbon filter we can concentrate the exotic chemicals present in the water.

In other words, we have a technique of concentrating the unnatural chemicals from thousands of gallons of the water supply into a few cubic centimeters [referring to exhibits]. After the desired quantity of water has passed through the filter, a solvent is used to remove the chemicals from the carbon and hence, by evaporation, the solvent itself is removed, leaving the composite sample of chemicals shown in the beaker. The next step is to develop a practical means to analyze this chemical residue.

The conventional methods of qualitative analysis of these complex chemical compounds are so involved and so costly that they are not practical for normal use. We are now exploring possible adaptations of the infrared absorption spectrometer to chemicals. We know, for example, that infrared light has a characteristic pattern of absorption of chemicals at different wavelengths so with the proper machines we can determine the percent of transmission and actually produce a graphic chart such as we have here [referring to exhibit]. This top chart was actually prepared from waste in an industrial sewer. Downstream some 70 river miles we can pick up the same chemical in the water supply at a city water intake. The bottom chart shows the same characteristic pattern after the water passes through the treatment process.

That is about where we are at the moment. The research we want to do is to standardize these fingerprints, so to speak, to develop a comparison method so we would be able to know in general what the chemicals are, and from what source they come. Our objective is to develop a technique that can be used in a water supply in a practical way and within the reach of the normal facilities of municipalities. This is an example of one of the things we are working on.

Mr. BUSBEY. Thank you very much.

FRIDAY, FEBRUARY 27, 1953.

GRANTS, WATER POLLUTION CONTROL

WITNESSES

MARK D. HOLLIS, ASSISTANT SURGEON GENERAL, DEPUTY CHIEF, BUREAU OF STATE SERVICES
CARL E. SCHWOB, CHIEF, DIVISION OF WATER POLLUTION CONTROL

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$900,000		$900,000
Prior year balance available	47,312	$20,223	
Total available for obligation	947,312	20,223	900,000
Balance available in subsequent year	−20,223		
Obligations incurred	927,089	20,223	900,000

Obligations by activities

Grants to States and interstate agencies for industrial waste studies, surveys, and research:	
1952	$927,089
1953	20,223
1954	900,000

Obligations by objects

11	Grants, subsidies, and contributions:	
	1952	$927,089
	1953	20,223
	1954	900,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$1,500		
Obligations incurred during the year	927,089	$20,223	$900,000
Total expenditures	928,589	20,223	900,000
Expenditures are distributed as follows:			
Out of current authorizations	928,589		900,000
Out of prior authorizations		20,223	

Mr. BUSBEY. The committee will come to order.

We have under consideration the appropriation request for grants for water-pollution control. Mr. Mark D. Hollis, Assistant Surgeon General, is here to testify on that item.

Mr. Hollis, we will be very happy to hear from you at this time.

Mr. HOLLIS. Thank you.

GENERAL STATEMENT

Mr. Chairman and members of the committee, this appropriation provides for grants to States and interstate agencies as authorized in section 8 (a) of the Water Pollution Control Act (Public Law 845 of the 80th Cong.).

This grant program, Mr. Chairman, is one of the five phases of the program which together form the pattern of cooperative State-Federal action designed to abate the pollution problem. This cooperative approach, maintaining as it does the primary right and responsibility for the control of pollution in the States, was devised in lieu of a strong Federal authority approach to this problem.

This grant item of $900,000 is specifically for research and studies on industrial wastes. It is the only grant provision of Public Law 845 which has been implemented. The act provides that these funds be used to aid in devising methods of industrial waste treatment which are not susceptible to present methods.

GROWING SIGNIFICANCE OF WATER POLLUTION PROBLEM

I believe, Mr. Chairman, that the published testimony of congressional hearings in recent years sets forth clearly the increasing significance of industrial wastes in the national water-pollution problem. We speak of the 700-percent increase in industrial production since 1900, often without fully recognizing that more than half of this increase has occurred in the past 12 years. What is more significant, much of this increased production is in the broad field of synthetics and other chemicals whose byproduct wastes are difficult to treat.

Over wide areas of the Nation water pollution is seriously damaging our water resources. It is a result of the inevitable byproduct wastes from our expanding industrial machine and growth of cities.

The treatment of industrial wastes is the responsibility of industry. It is not the intent that these funds be used to solve industrial-waste problems of any specific plant. Rather, these project grants are to be made for investigations on industrial wastes of national or regional significance.

You may recall, Mr. Chairman, when this appropriation was considered on the floor of the House last year the question was raised as to whether a sum of this size actually contributed much to each State or interstate agency in its efforts to solve the industrial-waste problem. The question was, Could not the States absorb the amounts of the grants under this appropriation? This question was not without some validity, as it related to the formula basis for allotting these funds to the States. Accordingly, we now propose to allocate funds on a project basis.

It is planned to explore some of the more important national and regional problems facing industry. This will enable us, cooperatively with the States, to concentrate on problems of highest priority. This has the added advantage of encouraging States to utilize the full potential of university and private research centers in meeting problems of industrial-waste pollution.

As to accomplishments, I think we must realize than in a problem as complex and varied as is the problem of water pollution by indus-

trial wastes, a resource of this magnitude can only be expected to solve a few of the many national problems. Actually, it will develop fundamental facts in the several broad fields, which in turn may be applied to the solution of specific problems. Most of the work done is not the type that will attract wide public attention or produce dramatic advances. However, it represents the hard core of investigation so essential in the orderly advance against the national pollution problem.

IMPORTANT RECENT DEVELOPMENT

The committee may be interested in a recent development, not yet released in the scientific literature, that resulted from a grant under our fiscal year 1952 appropriation. For years the problem of acid-mine drainage has plagued coal operators and the public alike. A small project grant was made to the Interstate Commission on the Potomac River Basin for sponsoring a piece of research in this field at Johns Hopkins University. This research project has produced a new concept that may well have far-reaching effects in abating the acid-mine drainage problem. Through this work it was discovered, for the first time, why and how air, water, and the mineral pyrite (fool's gold) unite within pyrite-bearing coal mines to produce more sulfuric acid than is manufactured annually in the entire world, and which in turn pollutes the streams. The Potomac Commission has submitted to us a grant request to permit further verification of this new concept and development of the techniques of field application.

It would be hard to overemphasize the potential significance of this finding. The effective ultilization of the water resources of the heavy coal-producing States, such as Pennsylvania, West Virginia, and Kentucky, hinge on a practical solution of the acid-mine drainage problem. We appear on the verge of finding such a solution.

PROJECT ALLOCATION OF FUNDS

Now a word as to the project allocation of these funds.

In addition to pressing our advantage on the problem of acid-mine drainage, we would favor exploration of specific problems involving: (1) Chemical wastes in connection with the rapidly expanding field of synthetics; (2) pollution associated with the petroleum industry; (3) the increasing significance of byproduct steel-manufacturing waste; (4) the byproduct waste of the rapidly developing fruit-juice-concentrate industry; and (5) some probing into the important problem of reclaiming byproduct waste materials for beneficial uses.

It would be difficult at this time to list in detail the project grants and the State and interstate agencies to which the grants will be made. While we know the problem areas, the making of a particular grant will depend on the resources available to the States and the availability to them of competent scientists and physical facilities necessary to attain the desired objectives.

Our close collaboration with interstate agencies and with the States through their national organizations, and our close working relations with industry through the now well-established National Technical Task Committee on Industrial Wastes, make us confident that the funds can be distributed equitably in the public interest. As an

added assurance, projects are carefully reviewed by our several advisory committees before the grants are made.

I should be glad to attempt to answer any questions pertaining to this appropriation.

FUNDS REQUESTED OF BUDGET BUREAU

Mr. BUSBEY. What was your original request to the Bureau of the Budget?

Mr. HOLLIS. $900,000.

Mr. BUSBEY. And the Bureau of the Budget allowed you the full amount?

Mr. HOLLIS. Yes, sir.

BACKGROUND OF 1954 ESTIMATE

Mr. BUSBEY. Of course, you are very familiar with the fact that last year on the floor of the House an amendment offered by Mr. Pickett to delete this item from the appropriation was passed on a division vote of 3 to 1.

Mr. HOLLIS. Yes, sir.

Mr. BUSBEY. I would not think that that is a very promising record on which to go before the House again this year for another appropriation of $900,000.

Mr. HOLLIS. May I have a moment to go into the background of that particular item?

Mr. BUSBEY. Surely.

Mr. HOLLIS. Under Public Law 845, this particular appropriation was made first in 1950, and subsequently in 1951 and 1952; $1 million was appropriated in 1950; $1 million in 1951; and $900,000 in 1952.

Our original plan with the States was this: That under the terms of the act we would use the funds over the first 4 years on a straight-formula allocation to States in an effort to build up the State competence in the industrial-waste field, and have the States, in those years, inventory their industrial-waste problems.

We felt that while over the years we had an excellent picture of the municipal pollution problem, pollution from cities, we have never had a clear picture of just what was being discharged from industries.

The States agreed with us that we would begin a shift from a formula grant to a project grant in the fourth and fifth years of the act, so that in the fifth year, certainly, we could concentrate the funds on specific industries and specific projects.

We felt some inadequacy in making it clear that on a formula basis there were very small amounts given to each State; but on a project basis we think that an appropriation of this magnitude would have some significance. This is especially true in the case of interstate commissions where their financial resources are set by laws ratifying the act by the individual States.

Mr. BUSBEY. There is nothing to keep the States from changing those laws, though.

Mr. HOLLIS. No; there is not.

Mr. BUSBEY. This table you have of obligations for 1952 on page 58 of the justification is more or less on a formula basis, and not as you propose doing in 1954 on a project basis?

Mr. HOLLIS. That is true. That is a straight-formula basis of a flat allocation for each State plus an allocation based on population and financial need.

PROJECTS AND STATES TO RECEIVE 1954 FUNDS

Mr. BUSBEY. Which projects have you planned to support through this program in 1954 if the Congress saw fit to appropriate this money?

Mr. HOLLIS. We have a list of 12 or 14 projects here.

The citrus-waste pollution problem associated with the rapidly increasing fruit juice-concentrate industry is beginning to be of serious concern to Southern and Southwestern States.

Mr. BUSBEY. What States would get that money and how much have you allocated for the project?

Mr. HOLLIS. $20,000. We have not determined which States would get it. The determination would be made after discussion with States who have similar problems.

In the East there is a pollution problem associated with the textile industry—dyes and so forth. We would allocate the funds to the States or group of States that would have the best research potential at their command to use the money. We estimated that at $30,000.

Mr. BUSBEY. How many States would participate in that project?

Mr. HOLLIS. Florida, Mississippi, and Texas, principally; Louisiana to a lesser extent, and Alabama to a lesser extent. There would be about five States.

Mr. BUSBEY. What is your next item?

Mr. HOLLIS. Acid mine drainage. This one we feel is of utmost importance and urgency, and we propose $50,000 for final verification of this new finding that we now have and for development of a technique. In other words, we want to get a technique developed so that the coal-mining industry itself, or the States which control abandoned mines, might use it as a practical approach in solving that problem.

Mr. BUSBEY. Which States would participate in that?

Mr. HOLLIS. This one we plan to grant to the Interstate Commission on the Potomac River Basin, composed of the States of Pennsylvania, West Virginia, Virginia, Maryland, and the District of Columbia. We feel they have the necessary law to do this work. It is a legally constituted body. We would make the grant to the Commission. These principles which they would develop would then apply in all the coal-producing States.

Mr. BUSBEY. What about the States of Illinois, Indiana, Kentucky, and Ohio, all of which produce a lot of coal?

Mr. HOLLIS. They are very much interested in this problem. Talking to State engineers in Illinois and Indiana recently, they had the preliminary release on this development. As the first step, rather than all States trying to work out the technique, let us get the best competence we can to develop the technique; then it would be applied across the country. We feel at Johns Hopkins we have the group that did the basic research. They are thoroughly familiar with the concepts, and they can follow through and make the technique available to all States with a similar problem.

Mr. BUSBEY. What is the next one?

Mr. HOLLIS. Effects of detergent pollution on water uses. This is a tough and involved problem. The increased use of detergents across the Nation is affecting our biological treatment of municipal sewage, and then as it passes to the streams it is affecting the whole biological life of the stream. We are not sure at what levels of concentration the bad effects are produced. We are having a great deal of trouble with fishkills, much of which is traceable back to industrial waste.

Mr. BUSBEY. How much is allocated to that?

Mr. HOLLIS. $16,000.

Mr. BUSBEY. Go down your other items and the amounts.

Mr. HOLLIS. Phosphate-waste studies, which do not affect as wide a geographical area, $15,000.

Mr. BUSBEY. Which States would get those funds?

Mr. SCHWOB. Florida and Southeastern States.

Mr. HOLLIS. Studies on treatment problems of textile waste, $30,000. We were going to do that in New England, but the results would have wide application in the Southern States too.

Studies of toxins from industrial waste. That is of particular interest in Oregon and California because of the effects on the fisheries industries, particularly the salmon and shellfish industries.

Mr. BUSBEY. What is that amount?

Mr. HOLLIS. $31,500.

The metal plating waste studies would be in one of the Midwestern States. That amount is $15,000. With the increased use of chemicals in metal plating the objective would be to determine the concentration the streams could absorb.

Evaluating stream improvement from abatement of industrial pollution, $12,000. That would go to Oregon because of their research potentials in that field.

Reclamation of waste materials, $35,000.

Prevention of mine tailings pollution, $35,000.

Plastic waste pollution, $25,000.

Fish autopsy studies, $20,000.

Treatment and reclamation of used industrial waste water in dry areas. In other words, to reclaim industrial water for irrigation in extremely dry areas in the West.

Mr. BUSBEY. What is that amount?

Mr. HOLLIS. $60,000.

In other words, in our work in former years under this appropriation, we developed a lead on lagooning of certain types of waste where land was not expensive. We found we can, by lagooning processes, reclaim the water at very little cost and reclaim a fertilizer value that can be returned to the land. We wanted to explore that same possibility in terms of other waste.

The last is the destruction of phenols and phenol derivatives. You may be familiar with the recent expenditures in the city of Chicago for water treatment plants. That was costing them about $4,000 a day additional treatment expense merely for activated carbon to remove the phenol taste coming from industry in Indiana and Illinois.

We are trying to correct that at the plant source and cut down on the treatment cost. That problem is widespread in the Ohio Valley, and we feel there is a good possibility of developing a means of de-

stroying the phenol derivatives at the source and thereby preventing the taste.

Mr. BUSBEY. What was the amount for that?

Mr. HOLLIS. $40,000.

Mr. BUSBEY. That totals up to what amount?

Mr. HOLLIS. That totals approximately $450,000, without checking the figures exactly.

ADDITIONAL PROJECT ALLOCATIONS PROPOSED

Mr. BUSBEY. What would you do with the other $450,000?

Mr. HOLLIS. This is a compiled list of what is now in the form of a request before the Public Health Service. We have not made any request of the States, or any suggestion that the States submit projects under this program. These proposals have been assembled in terms of whether or not our small research potential at Cincinnati could get to them, or if any funds could be made available for them; these projects we think are quite urgent.

Mr. BUSBEY. Has there been any great demand for these projects that you have outlined here from any particular source, or are these projects that you think should be gone into if the funds are available?

Mr. HOLLIS. These represent specific requests that have come to us from either our Industrial Waste Task Committee or from the two associations of the States which I have mentioned, or they have come to us from the interstate agencies. We concur with these. There have been, obviously, many other requests we felt were too narrow in scope, such as a request for treating the wastes of a particularly complex industry, which we feel should be financed by that particular industry. These are regional or national problems.

DETERMINING APPLICATION OF FUNDS UNDER PROJECT GRANT SYSTEM

Mr. BUSBEY. But there has been a definite, specific request from some association or some State agency for you to initiate all these projects for which you have allocated $450,000?

Mr. HOLLIS. Yes, sir.

Mr. BUSBEY. And if $900,000 were made available, then you would look around for other projects to consider going into; is that it?

Mr. HOLLIS. Yes, sir. We frankly admit that when you shift to a project grant, care must be taken to avoid arbitrary decisions on the part of our own office in the application of funds. Our mechanism would be this: Under the terms of the act we have a National Water Pollution Control Advisory Board. This problem would go before that group first. Then we have the Industrial Waste Task Committee, composed of 57 members representing 34 major industrial groups, like paper and paper pulp. We would go before that group. Then, of course, we would go to the State groups, since the money must be granted to States or interstate agencies. From this effort we would come up with specific projects and the amounts that would be allocated.

Mr. BUSBEY. This $450,000 to be allocated would amount to less than an average of $9,000 per State when you take into consideration the 48 States, Alaska, Hawaii, and Puerto Rico.

Mr. HOLLIS. Yes, but it would not be divided among them. It would be put in a specific State or group of States. In other words, under this plan some States would not participate directly in the grant, but would derive benefits from it.

CHANGE TO PROJECT BASIS OF MAKING ALLOCATIONS

Mr. BUSBEY. When was it determined to use a project basis for allocating 1954 funds?

Mr. HOLLIS. The original plan was devised in fiscal year 1950, at the time of the passage of the act. As a matter of fact, we proposed with the first money that we might go right into a project basis. The States felt, however, that the greatest immediate need was to make surveys and investigations to determine where the industries were and the types of industrial pollution entering the streams.

Mr. BUSBEY. Did not the States know that already?

Mr. HOLLIS. They knew it for cities, but not for industries.

We have it fairly well completed now, and I might say in 1950 when this act was passed and funds were made available, the States were expending $2 million a year in total for their water pollution control work. With this stimulation to get an addition to their staff, to get an industrial-waste man or two on, the State expenditures have now increased to about $5 million a year, and we felt that as they developed their staffs, these funds should be shifted to a project basis in order to get more specifically at the heart of some of the tough industrial-waste problems.

Mr. BUSBEY. On this question of grants, especially grants to States, I have been expressing my own viewpoint to all of those who have come before this subcommittee. In view of the fact that practically all the States have reduced their bonded indebtedness—some have paid theirs off entirely—and that practically all the States have been increasing their cash position by millions of dollars every year; somewhere along the line the States are going to have to assume these responsibilities themselves instead of looking to the Federal Government to take care of such matters for them. That is a very honest, sincere position that I am taking. I cannot speak for the rest of the committee, and I cannot speak for the other Members of Congress, but I do not want to be accused of flying under false colors by not making known to people who appear before this committee my own viewpoint. If this trend does not stop we will drift into a totalitarian government without knowing it, and I am determined to do what I can to stop it. I cannot see why coal-mining States, for example, cannot get together and meet this problem of acid pollution. It seems to me that the States with coal-mining problems would have educational institutions and State agencies with men qualified to deal with the problems confronting the industry all the time. And that goes as well for the textile and other industries you have enumerated to this committee.

So that is a problem the solution of which I think is very fundamental to the whole economy of our country. Our national debt has been going up and up by the billions, while the States have been reducing their debts. Therefore, I sincerely believe that many of these problems that are being handled by grants from the Federal

Government—which means taking money from the States and putting it back into the States—have to be halted somewhere along the line.

RELATIONSHIP TO OTHER FEDERAL AGENCIES AND TO STATES

Mr. BUDGE. In this connection, I noticed in one of the local papers the other day a breakdown of income taxes collected, both personal and corporate, in various States. The return to the States amounted to about 6½ percent of the amounts collected in the States.

Are you familiar with the work being done in this field by the United States Geological Survey?

GEOLOGICAL SURVEY

Mr. HOLLIS. Yes, sir. The work of the United States Geological Survey in this field is largely on ground waters, the mineral content of ground waters. Our Division of Water Pollution Control works closely with them on that.

Mr. BUDGE. Of course there is no minimizing of the problem. We all realize it is a serious problem. However, the United States Geological Survey has been established for many years, not only to work on ground waters, but on streams, and they do that very generally. This past week, serving on another committee, I have heard the testimony of the Geological Survey officials, and in many respects it coincides with what you are talking about. I noticed the Bureau of Reclamation wanted to go into a similar program.

It seems to me all these boards, bureaus, and so forth, should be centralized in one agency, and I am rather of the opinion that in view of the fact the Geological Survey has been working with both ground and stream waters for many years, the logical agency to do this work is the Geological Survey instead of your agency. Would you care to comment on that?

Mr. BUSBEY. If the gentleman from Idaho will yield, you will see on page 130 of the committee print of the justifications that the United States Public Health Service has elsewhere in its budget $1,360,000 for "Water supply and water pollution control." How many agencies of the Government do you think are interested in this problem and doing work on it?

Mr. HOLLIS. On the pollution problem, the pollution from city sewage and industrial waste, our agency is the one focusing in that particular field. The Department of Agriculture is working on silting problems of land use that result in soil erosion and silt getting into streams. The Geological Survey is working on the chemical quality of waters, and it is my understanding on a desalting project, reclaiming sea water.

But this problem of water pollution, under the concept of Public Law 845 the prime responsibility and authority is to remain in the States. The efforts of the Public Health Service, again in terms of the act, are limited to a few cooperative programs in an effort to support and help the States work out some of the complications involved. This particular appropriation relates to this one item: grants for work on industrial waste pollution.

Mr. BUDGE. Mr. Chairman, Mr. Hollis has just mentioned that the Geological Survey is working and has been working for some time on

removing salt from seawater. The Bureau of Reclamation has a substantial request before this Congress to do the same thing. The Fish and Wildlife Service is also working on the salmon problem Mr. Hollis was talking about; and the Bureau of Mines is working on the mine tailings problem. It looks like each agency is looking into the water to see what is in it, and those efforts should be concentrated in one agency.

INTERAGENCY RIVER BASIN COMMITTEE

Mr. BUSBEY. Is there any coordination of the various agencies working in this field?

Mr. HOLLIS. Yes, sir; there is. We have the interagency River Basin Committee, which is composed of all the Federal agencies concerned with that phase of total water resources and land use.

Mr. BUSBEY. Are there any agencies in that Commission that have not been named here this morning?

Mr. HOLLIS. Yes, sir. The Department of Commerce is among that group and the Federal Power Commission, the Army engineers, and then, of course, the Department of the Interior and the Department of Agriculture, together with the Federal Security Agency. These agencies comprise the total list.

Mr. BUSBEY. Mr. Fernandez?

USE OF FUNDS IN NEW MEXICO

Mr. FERNANDEZ. I notice in the justifications for 1952 some $9,500 was distributed to my State. I take it that comparable amounts were distributed for the previous years to that State.

Mr. HOLLIS. Yes, sir; since there were three different annual appropriations under this particular appropriation for the years 1950, 1951, and 1952.

Mr. FERNANDEZ. Who in the State handled those funds that were sent to the State of New Mexico?

Mr. HOLLIS. In your State, sir, the department of health is designated by the State as the sole water-pollution agency.

Mr. FERNANDEZ. How were those moneys used in the State?

Mr. HOLLIS. In that particular State, it was used for the employment of an engineer in the industrial waste field to inventory the industrial problem—the effects of industrial wastes on the streams.

May I ask Mr. Schwob to answer that as Chief of the Division of Water Pollution Control?

Mr. SCHWOB. Dr. Scott and Mr. Caldwell, the chief engineer in New Mexico, employed Mr. Robert Lowe out there to investigate the industrial waste problems that you have in petroleum. I do not know the details of what they went into in the petroleum field, however.

Mr. FERNANDEZ. You do not know how the money was used?

Mr. SCHWOB. It was used all over the State to determine their industrial waste problems in the State of New Mexico.

Mr. FERNANDEZ. You do not know what was accomplished with it?

Mr. SCHWOB. No, sir; I do not.

Mr. FERNANDEZ. You do not know whether they investigated the pollution of water in the mining areas recently developed?

Mr. SCHWOB. I am sure they did include that in the survey of the State. I am sorry, sir, I do not have a copy of the Southwest report, which sets forth the various phases of pollution, both domestic and industrial, in the State of New Mexico and by various river basins. I can see that you get that if you want it.

Mr. FERNANDEZ. There is some pollution in New Mexico by certain industries about which we have been advised. Those industries are not very large, but they are large enough that they could put up this money for the State, if the State required it. The amounts are small.

Mr. HOLLIS. Of course, we recognized under the formula grant basis that we were not putting this money where the biggest industrial problem existed. However, we did feel if we were going to make a formula grant, it had to be on the basis of a mathematical formula for each State.

Mr. FERNANDEZ. It was merely designed originally to get the States interested in the problem?

Mr. HOLLIS. The purpose was to get the States started with the full intention of shifting it entirely to them later.

Mr. FERNANDEZ. Do you have a copy of section 8 (a) of the act under which this appropriation is requested?

Mr. HOLLIS. Yes, sir; I do.

POTOMAC RIVER COMMISSION

Mr. FERNANDEZ. You started to tell us about the Potomac River Commission action, and you did not complete your sentence a while ago. I was wondering what it was about.

Mr. HOLLIS. Was that in relation to the method of financing?

Mr. FERNANDEZ. Yes. You started to tell us about the problems you had in the various States because of restrictions in the various States, and you started to mention the Potomac River Commission action.

Mr. HOLLIS. For most of the interstate commissions, authorization for the States to form an interstate compact is approved by the Congress, and then each State has to ratify it. Generally, in so doing they stipulate the amounts that can be appropriated within the States to go for this particular State function—that is, that part of the apportionment of that State's financial responsibility to the interstate commission.

The Potomac River Commission is so constituted. Any increase over their existing budget—that is, to provide any additional expenditures or programs such as the acid mine drainage problem—the only recourse they would have would be to go back to the States for an amendment of the act. The difficulty is that all the States that belong to the interstate commission must ratify the amendment, or it would not be effective. So it is the time element; for example, the Potomac River Commission amendments I do not think have been ratified by any State as yet.

Mr. SCHWOB. I am not sure about that.

Mr. HOLLIS. It would take several years, of course, to get approval of all the State legislatures.

Mr. FERNANDEZ. Well, you aroused my curiosity, and I wanted it satisfied. If you do not have the material on the Potomac River Commission, it is all right.

How much of these funds go to administration on your part?

Mr. HOLLIS. $10,000.

Mr. FERNANDEZ. That is all.

REQUIREMENTS FOR STATE REPORTING

Mr. BUSBEY. Just one thing more. Were the States that received funds in 1952 required to make a written report back to you on how these funds were spent and what was accomplished?

Mr. HOLLIS. They were not required by law under the terms of the act, but they did. I do have, for example, reports from the States, and in some cases they have combined the reports by areas, such as the area of New England, which show the results of the surveys as to the industrial waste problem. So we do get them, but the law does not require that they report.

Mr. FERNANDEZ. You do not have any more information as to what they have done in the other States than you have in my own State?

Mr. HOLLIS. Yes, sir. We have the report from your State, but we happen not to have it with us. We have these industrial waste inventories and we have the joint statement of the Public Health Service and State health departments by river basins, which reports show the actual accomplishments in this field.

Mr. FERNANDEZ. It would show that something has been accomplished by them and if so what?

Mr. HOLLIS. If I may, I would like to amplify that point just a moment. I think the greatest tangible accomplishment that has been made to date under this act has been that the State structures are being strengthened. In other words, the machinery has been set up, and the water pollution authorities in the several States have been strengthened, we are confident. It is reflected in one sense by the fact that the States now appropriate $5 million for support of water policies control machinery as opposed to $2 million in 1950.

I am perfectly frank in saying that in terms of recent abatement of pollution the greatest achievements have been in industry. It is hard to measure these, because most abatement in industry is not measured by the construction of a huge waste-treatment plant. Rather, it is measured by adjustments within the industries which eliminate the pollution. For example, in the Fairless steel plant on the Delaware River, in working with that waste problem, they have utilized a means of reclaiming the steel and the waste products that formerly went into the stream. These are put back into the production line and are actually used for production.

So, in that sense, it is hard to give you an accounting, but in terms of construction of city treatment plants, the program is much too slow. We had built up to a $200 million per year construction program in 1950, but the defense buildup and the curtailment of material and shortages of material have dropped it back, and in 1952, when the figures are compiled, they are going to show less than a $150 million building program.

BASIS FOR CHANGE TO PROJECT GRANT SYSTEM

Mr. FERNANDEZ. In any event, you think we have gotten the States and the State legislatures conscious of the problem, and that hereafter any appropriation that is made will be concentrated in areas where such further work may be necessary instead of distributing it nationwide?

Mr. HOLLIS. Yes, sir. That was the basis for this shift from a formula basis to a project basis.

FUNDS SPENT BY GOVERNMENTAL AND PRIVATE UNITS

Mr. BUSBEY. Mr. Hollis, it seems to me the States must have had to supplement these funds granted to them in 1952 by much larger amounts of their own to accomplish anything.

Mr. HOLLIS. Yes, sir.

Mr. BUSBEY. Now, we have industry spending a lot of money on these problems; we have States spending a lot of money on these problems; and we must have large cities spending a lot of money on these problems. What would you estimate to be the total amount of money which was spent in 1952 by all, including the private interests, communities, and State agencies?

Mr. HOLLIS. May I ask, Mr. Chairman, would you exclude construction cost in that question? For example, we know the cities themselves spend about $150 million a year for construction.

Mr. BUSBEY. Yes; I would exclude construction.

Mr. HOLLIS. In terms of actual expenditures on efforts to abate and reduce pollution, we know specifically that the States in 1952 spent $5 million. I would think the cities would have a negligible amount, because their work on the abatement problem would be by the construction of treatment facilities for their own pollution problems. In terms of industry, it would be difficult to place any tangible figure on their expenditures. Industries are spending large amounts on in-plant and process changes which often have the result of reducing pollution.

Mr. BUSBEY. In addition to water pollution, the cities and industries must spend a tremendous amount of money for these various other projects that you listed this morning, those that you have anticipated in your 1954 program, have they not?

Mr. HOLLIS. Not in terms of working on these problems from the standpoint of their pollution effects and ways and means of treating them. No, sir; they do not.

Mr. BUSBEY. You mean to say, for instance, that the fruit industry is not taking into consideration and trying to clear up the acid-content problem?

Mr. HOLLIS. They are quite concerned about it; yes, sir; but for the overall problem there is no program to develop methods of handling it, and that is what is needed. That is the purpose of our getting into it, and our view was to help develop some practical method of handling this huge fruitpulp waste from the industry. Once that is worked out, industry will handle the application.

Mr. BUSBEY. Any further questions? If not, thank you very much, gentlemen.

WEDNESDAY, MARCH 25, 1953.

DISEASE AND SANITATION INVESTIGATIONS AND CONTROL, TERRITORY OF ALASKA

WITNESSES

DR. JACK C. HALDEMAN, ASSISTANT CHIEF, BUREAU OF STATE SERVICES

DR. OTIS L. ANDERSON, CHIEF, BUREAU OF STATE SERVICES

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$1,229,179	$1,107,500	$1,107,000
Reimbursements from other accounts	981		
Total available for obligation	1,230,160	1,107,500	1,107,000
Unobligated balance, estimated savings	−9,289		
Obligations incurred	1,220,871	1,107,500	1,107,000

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
Direct obligations			
1. Special grant to Alaska for general health purposes	$630,000	$540,000	$540,000
2. Direct operations:			
(a) Technical assistance to Alaska	132,557	118,000	118,000
(b) Field and laboratory investigations	395,015	387,100	387,000
(c) Administration	62,318	62,400	62,000
Total direct obligations	1,219,890	1,107,500	1,107,000
Obligations payable out of reimbursements from other accounts			
2. Direct operations: (b) Field and laboratory investigations	981		
Obligations incurred	1,220,871	1,107,500	1,107,000

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Total number of permanent positions	75	71	68
Full-time equivalent of all other positions	1	1	1
Average number of all employees	67	66	65
Average salaries and grades:			
General schedule grades:			
Average salary	$4,311	$4,161	$4,068
Average grade	GS–6.2	GS–6.3	GS–6.2
Crafts, protective, and custodial grades:			
Average salary	$2,860	$2,781	$2,781
Average grade	CPC–4.2	CPC–4.0	CPC–4.0
Ungraded positions: Average salary	$5,490	$6,450	$6,450
Direct obligations			
01 Personal services:			
Permanent positions	$338,563	$336,928	$331,548
Part-time and temporary positions	2,798	3,610	3,610
Regular pay in excess of 52-week base	869	698	698
Payment above basic rates	68,084	66,224	65,344
Total personal services	410,314	407,460	401,200
02 Travel	43,493	40,500	45,500
03 Transportation of things	11,921	12,050	12,810
04 Communication services	4,103	1,800	1,800

Obligations by objects—Continued

Object classification	1952 actual	1953 estimate	1954 estimate
Direct obligations—Continued			
05 Rents and utility services	$41,423	$42,000	$42,000
06 Printing and reproduction	1,802	1,250	1,250
07 Other contractual services	10,461	7,400	7,400
08 Supplies and materials	54,868	45,695	45,695
09 Equipment	10,321	8,100	8,100
11 Grants, subsidies, and contributions	630,000	540,000	540,000
15 Taxes and assessments	1,184	1,245	1,245
Total direct obligations	1,219,890	1,107,500	1,107,000
Obligations Payable Out of Reimbursements From Other Accounts			
Travel	671		
Supplies and materials	310		
Total obligations payable out of reimbursements from other accounts	981		
Obligations incurred	1,220,871	1,107,500	1,107,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$153,882	$74,676	$77,176
Obligations incurred during the year	1,220,871	1,107,500	1,107,000
	1,374,753	1,182,176	1,184,176
Deduct:			
Reimbursable obligations	981		
Adjustment in obligations of prior years	6,364		
Unliquidated obligations, end of year	74,676	77,176	79,176
Total expenditures	1,292,732	1,105,000	1,105,000
Expenditures are distributed as follows:			
Out of current authorizations	1,157,178	1,040,000	1,040,000
Out of prior authorizations	135,554	65,000	65,000

Mr. BUSBEY. We next have before us for consideration the appropriation request for fiscal year 1954 for disease and sanitation investigations and control in the Territory of Alaska.

I believe you have a general statement on this item, Dr. Haldeman.

Dr. HALDEMAN. Yes, sir; Mr. Chairman.

Mr. BUSBEY. You may proceed.

GENERAL STATEMENT

Dr. HALDEMAN. Mr. Chairman and members of the committee, the appropriation, "Disease and sanitation investigations and control, Territory of Alaska," provides funds to assist Alaska in the development and maintenance of its overall public-health program. It also provides funds for research, fundamental to solving many of the public-health problems peculiar to low-temperature areas.

SPECIAL HEALTH PROBLEMS BECAUSE ALASKA IS LOW-TEMPERATURE AREA

Alaska, like other low-temperature areas, has many serious health problems. The high tuberculosis death rate, high accidental death rate, high death rate from acute communicable disease, and high incidence of gastroenteric disease are but examples. However, the

methods of transmission, the epidemiological pattern, as well as the clinical picture of disease in low-temperature areas often differ widely from those found in temperate climates. Provision of suitable housing, water supply, and waste disposal is handicapped because of low temperatures. We feel that these problems are not insurmountable, but they require much further study if economical and satisfactory solutions are to be found.

MILITARY SIGNIFICANCE OF ALASKAN HEALTH PROGRAM

The military importance of the low-temperature areas of North America is due to the fact that the shortest air routes between the Eastern and Western Hemispheres lie across the Arctic. Alaska is undergoing not only the usual consequences of becoming a vast defense impact area but it is also entering a critical period of industrial development and expansion. It is confronted with aggravation of its sanitation and housing problems—which I think are without parallel in any other defense boom area, even during World War II. At the same time, it is struggling to establish a permanent, year-around economy based on a vastly expanded utilization of virtually untapped natural resources. An example of this is the recent decision to build a $400 million aluminum plant in Alaska. This will result, during the construction phase, in a completely new town of 20,000 people. A new paper-pulp industry is emerging, and exploration for oil and uranium is increasing. This forced development of Alaska has been marked by an influx of military and civilian population which has accentuated the already acute health and sanitation problems of the area. Accurate data regarding population increases are not available, but there has been a 269 percent increase in the population of Territorial schools over the 1942–43 school year—and almost a 100 percent increase over the 1947–49 school year which incidentally, is the year in which this program was initiated.

These problems were recognized by Congress in 1948 when the chairman of this subcommittee, on his own initiative, called hearings to consider the problem. This special Alaska health appropriation was passed as a result of the findings of these hearings. Its objective was to assist the Territory in meeting, in the best way possible, its most immediate and crucial health problems.

PHASES OF ALASKA HEALTH AND SANITATION PROGRAM

But there was another factor added. It was also recognized that these "first aid" measures would have to be reinforced by careful investigation and research to work out special methods for solving the particular problems inherent in a low temperature environment. Accordingly, the Alaska health and sanitation program was established in three parts:

(1) The provision of supplemental funds to augment those provided by the Territory for establishing the necessary health services;

(2) The loan of specialized personnel to the Alaska Department of Health to help administer these services; and

(3) The establishment of a program of research and investigation to study the underlying causes and differences involved in low-temperature health problems.

The first phase of this program, the provision of special grant funds, has enabled the Health Department to expand its program so as to render health services to many isolated areas to which such services had never before been available. During the same period the Territorial legislature has recognized the Territory's own responsibility in the matter. Whereas only about $70,000 was appropriated for health purposes for the biennium beginning in 1943, over $1 million was appropriated for the biennium beginning in 1951. This represents a per capita expenditure for general health purposes exceeded only by two States and an expenditure for tuberculosis hospitalization higher than that of any other State or Territory. However, when the amount of money available for public-health activities excluding hospitalization is considered, there has been an actual decrease of $241,000, or 18 percent, in the last 3 years. This has resulted from a decrease in Federal grant-in-aid funds, and has forced many contractions in program, including discontinuance of the operation of mobile health units, as of October 1 of this year.

It should be pointed out that Alaska's taxing ability is limited due to its small population, and many of its public-health problems have been federally created. The assignment of trained Public Health Service personnel to the Alaska Department of Health is serving to stimulate the development of organized programs of health service in many areas. This type of assistance to the Territorial Health Department has been of particular importance in view of the difficulty experienced by the Department in recruiting.

ARCTIC HEALTH RESEARCH CENTER IN ANCHORAGE

The Arctic Health Research Center in Anchorage is the outgrowth of the establishment of the third phase of the assistance to Alaska program—that of research and investigation. Now in its fourth year of operation, the center is steadily accumulating factual knowledge concerning a variety of health problems and conditions as they exist in Alaska. Studies currently in progress at the center cover a wide range of topics, including the relation of low temperature to nutritional deficiencies; the effects of freezing on living tissue—so important in finding answers to the problems of frostbite and trenchfoot; the distribution patterns of various types of disease; the existence and potential danger to man of certain animal-borne diseases—since, in Alaska, as in other low-temperature areas, man lives in close proximity to many wild and domesticated animals; suitable methods of insect control for low-temperature areas—since control methods suitable for temperate climates will not work in Alaska; and the investigation of methods designed to prevent freezing of water-distribution and sewage-disposal systems. This is especially important, since 10 to 15 percent of construction costs go into sanitary facilities, and conventional systems will not work at extremely low temperatures. Since construction contracts involving many millions of dollars are let annually in Alaska, considerable economy could be effected if we had answers to these problems now.

Some progress has been made already. For instance, the center has demonstrated that typical septic tanks, with certain modifications, will work in many areas where they had not been considered feasible, thus solving one of the more difficult problems relating to single-

premise sanitation. Important data have also been collected on the operation of community water distribution and sewage-disposal systems. Through its several lines of investigation, the center has also uncovered facts which have been of considerable assistance in developing other sound public-health programs. For example, although reliable statistical evidence was not available until fairly recently, it was generally accepted that tuberculosis was a leading cause of death in the Territory. A recent statistical study of tuberculosis conducted by the Arctic Health Research Center has not only confirmed this general belief but has also revealed racial and geographic variations in tuberculosis infection which are highly significant. Illustrative of this situation is the discovery that in the Yukon Delta region of Alaska, 90 percent of the Eskimo children in the 5- and 8-year group were found to be tuberculin sensitive. This is the highest such rate which has been reported anywhere in the world. Among the Eskimo and Indian children of interior Alaska, the rate was 65 percent. In southeast Alaska 22 percent were reactors, and among white children of the Territory the rate was substantially lower. Obviously the same methods of control cannot and should not be established for all these areas.

These are a few examples of the types of health activities and research which this appropriation is making possible in Alaska.

I will be glad to answer any questions you may have on this appropriation.

EXPENDITURES OF ARMED FORCES ON ALASKAN HEALTH RESEARCH

Mr. BUSBEY. How much are the Armed Forces spending on health research in Alaska, Doctor?

Dr. HALDEMAN. That is difficult to estimate, Mr. Chairman. They operate an aeromedical laboratory in Fairbanks. The actual budget of the laboratory at the time I was there in 1951 was considerably less than $100,000. However, they use it as a field station for projects that are developed at some of their bases here in the States.

Their work is related principally to use of rations in low-temperature areas, the development of suitable clothing and equipment and the type of equipment necessary for military operations in low-temperature areas.

PUBLIC HEALTH SERVICE FUNDS AVAILABLE TO ALASKA

Mr. BUSBEY. Can you give us a figure on what the Public Health Service is spending in grants for services to Alaska in addition to this appropriation?

Dr. HALDEMAN. Yes, sir. I have a table which illustrates this—the total Public Health Service funds available to Alaska for fiscal years 1952 and 1953.

Mr. BUSBEY. Without objection, we will put this table in the record so we will have those figures to guide us.

(The table is as follows:)

Public Health Service funds available to Alaska for fiscal years 1952 and 1953

	1952 appropriation	1953 appropriation	1953 in relation to 1952
Control of venereal disease:			
Grants-in-aid	$15,100	$15,000	−$100
Special projects	971	9,800	8,829
PHS direct expenditures	10,700	8,180	−2,520
Total	26,771	32,980	6,209
Control of tuberculosis: Grants-in-aid	76,700	66,600	−10,100
Assistance to States, General: Grants-in-aid	49,000	48,400	−600
Grants, water-pollution control	7,800		−7,800
Disease and sanitation investigations and control, Territory of Alaska:			
Grants-in-aid	630,000	540,000	−90,000
PHS direct expenditures	132,915	118,000	−14,915
Total	762,915	658,000	−104,915
Assistance for hospital construction: Construction grants	200,000	200,000	
Operating expenses, National Cancer Institute: Grants-in-aid	9,900	10,000	100
Mental health activities: Grants-in-aid	19,200	19,200	
Operating expenses, National Heart Institute: Grants-in-aid	10,300	10,400	100
Grand total	1,162,586	1,045,580	−117,006

Mr. BUSBEY. On page 3 of your statement you referred to the increase in the amount of money that the Territory of Alaska has appropriated; $70,000 was appropriated for health purposes for the biennium beginning 1943 and over $1 million was appropriated for the biennium beginning in 1951. That reference is to the Territory of Alaska appropriations; is that right?

Dr. HALDEMAN. That is correct, sir.

Mr. BUSBEY. What did the Public Health Service spend in Alaska in these two bienniums?

Dr. HALDEMAN. I do not have the figures here, but we can supply them for the record.

Mr. BUSBEY. All right.

(The figures are as follows:)

Public Health Service funds available to Alaska for health purposes for the periods July 1943 to June 1945 and July 1951 to June 1953

Fiscal year	Alaska grant	Other Public Health Service appropriations	Public Health Service direct expenditures	Total
1944		$95,091		$95,091
1945		99,295		99,295
Total		194,386		194,386
1952	630,000	[1] 388,971	$600,134	1,619,105
1953	540,000	[1] 379,400	564,770	1,484,170
Total	1,170,000	768,371	1,164,904	3,103,275

[1] Includes hospital construction grants, $200,000.

Mr. BUSBEY. Your request for appropriation, Doctor, is $1,107,000?

Dr. HALDEMAN. That is correct.

Mr. BUSBEY. Which is $500 less than for fiscal year 1953?

Dr. HALDEMAN. That is correct, sir.

FUNDS REQUESTED OF BUDGET BUREAU

Mr. BUSBEY. And what did you ask the Bureau of the Budget for?
Dr. HALDEMAN. We requested $1,160,000.

REASONS FOR SPECIAL PROGRAM FOR ALASKA

Mr. BUSBEY. Alaska participates in funds appropriated under "Assistance to States, general," and other public health grant programs just like a State does; does it not?
Dr. HALDEMAN. That is correct.
Mr. BUSBEY. So why should it get an extra appropriation any more than should Puerto Rico or, let us say, Illinois?
Dr. HALDEMAN. Mr. Chairman, under our grant formula, with the very small and widely scattered population in Alaska, with the tremendous impact of a forced development of the Territory, the total assistance from our regular grant-in-aid programs was very small. For instance, in 1953 under venereal disease they would have secured $33,000, and for tuberculosis, with their tremendous tuberculosis problem, $67,000. Under "Assistance to States," it would have been $47,000.
You must keep in mind that a map of the Territory of Alaska, if superimposed upon the continental United States, would touch all four borders. There are tremendous distances, there are tremendous environmental problems associated with climatic conditions, there are tremendous health problems. For that reason, I think it was, Congress saw fit to deal with the Territory of Alaska in a special appropriation.

LEGISLATIVE AUTHORITY

Mr. BUSBEY. What legislation authorizes this special treatment of Alaska?
Mr. HARLOW. I do not think there is any, Mr. Chairman. I think this is point-of-order language for the most part.
Dr. HALDEMAN. I might add that the grant portion would be subject to point of order; the authority for research, I believe, is contained in the Public Health Service Act.

ALASKAN PROGRAM ADMINISTERED BY BUREAU OF INDIAN AFFAIRS

Mr. BUSBEY. Doctor, are you acquainted with the appropriations that are made for Alaska health programs under the Bureau of Indian Affairs?
Dr. HALDEMAN. Yes, sir.
Mr. BUSBEY. How do those appropriations compare to those received by the various States that participate in the Bureau of Indian Affairs appropriation?
Dr. HALDEMAN. I could not answer as to how the relation of its appropriation to Alaska beneficiaries of the Office of Indian Affairs compares with the size of the appropriation for the Office of Indian Affairs' beneficiaries in other States. I am familiar with their program in Alaska.

Mr. BUSBEY. What does that appropriation amount to?

Dr. HALDEMAN. The appropriation for health amounts to something over $4 million. This appropriation is used primarily for hospitalization of the beneficiaries of the Office of Indian Affairs.

MODE OF TRAVEL OF ALASKAN STAFF

Mr. BUSBEY. I notice in the language of the bill that is shown on page 133 of the committee print that it includes "Hire, operation, and maintenance of aircraft." How much is spent on that?

Dr. HALDEMAN. To my knowledge there has been no money spent on this activity.

Originally, when the appropriation language was drafted there was a proposal that since health officials, nurses, and physicians have to depend largely on aircraft for their transportation, it might be more economical for them to utilize this means rather than chartering flights.

As a matter of fact, the Territory with its own money bought a plane, a surplus plane. However, it was destroyed by fire on the field at Oklahoma City before it got there.

No money out of this appropriation has been spent for that purpose since the first appropriation.

Mr. BUSBEY. How do they manage to get around?

Dr. HALDEMAN. Alaska is probably more airminded than any place in the world. The isolated areas of Alaska are served by plane, bush pilots, so-called, and the rates are comparatively low. However, it is the only means of transportation over many parts of Alaska.

Mr. BUSBEY. Are they ever able to use Defense Department transportation?

Dr. HALDEMAN. No, sir. The Defense Department has had to very rigidly live up to the provisions of the regulations relating to civilian traveling on military planes. I should say that the Defense Establishment, through the rather famous 10th Rescue Squadron, has been of immeasurable assistance to the Territory through their provision of emergency assistance. I never knew them to turn down a call for a mercy flight if there was somebody sick in a village, or marooned, or otherwise needing emergency care.

REQUEST RELATING TO PORTABLE BUILDINGS

Mr. BUSBEY. I notice that you are asking for some new language this year for the purchase, erection, and maintenance of portable buildings. Why?

Dr. HALDEMAN. Many of our field investigations require some sort of small facility.

I will give you an example of something that occurred last summer. Some of our epidemiological investigations were centered around Eklutna Valley, which is on the rail line. The center could have purchased an old boxcar to use for office space, but it was unable to because of lack of authority.

This appropriation does not provide for, as you will notice, any increase in contractual services, so it is only contemplated that the item will be used for small buildings in areas where field investiga-

tions are going on and where it is not possible to rent temporary quarters.

Mr. BUSBEY. You mentioned the great distances in Alaska as one of the reasons for special treatment. How does the total Public Health Service grant to Alaska compare with the total grant to New Mexico, which also has a widely scattered population?

Dr. HALDEMAN. In what terms?

Mr. BUSBEY. In terms of total appropriations.

Dr. HALDEMAN. New Mexico obtains grants from the Public Health Service under the terms of the allotment formula, and except for the 5-percent factor of sparsity of population contained in "Assistance to States, general," appropriation, does not have any special consideration.

Mr. BUSBEY. Mr. Fogarty.

PROGRESS OF SANITATION WORK

Mr. FOGARTY. Doctor, are you making much progress as far as sanitary improvements in Alaska are concerned?

Dr. HALDEMAN. Mr. Fogarty, we feel we are beginning to get some answers.

The problem, if I might enlarge on your question just a little bit, is something like this:

There is a method which is used in most military construction by which you can lick the problem as far as sanitary facilities are concerned. That is through the construction of utiladors, which is either a walk-through or crawl-through concrete box through which you put your water supply and waste disposal pipes and perhaps also put steam through it to heat. But for civilian development it is entirely out of the question. Even a 2-by-2 box costs over $5,000 to run in front of a 50-foot lot, which would increase the cost of the average home out of all proportion to what the owner could afford.

So our approach has been to try to develop means that will assist in the economic development of the Territory. We have some of the answers.

I mentioned one in the septic tank for single premise, which we are operating, incidentally, at the University of Alaska, and have operated for 3 years now. We have put the pipe in permafrost. We have modified it through the use of heating cables.

One of the problems, for instance, in Anchorage, where I lived, was that the average per capita consumption of water during January ran about 600 gallons a day, which was due to the fact that the folks had to leave their taps running to prevent freezing. At the center we developed a recirculating device which will in many instances permit a takeoff and a return from the same pipe, water main outside, which will keep the water in circulation.

In regard to waste disposal, we have made observations now for over 3 years, having thermocouple equipment in the present disposal system in Fairbanks, which is, incidentally, a very good place to study because it has cost some $10 or $20 per capita to keep those pipes open during the winter.

We have found there are some pretty general principles that might be followed and that might eliminate a large percentage of the trouble.

For instance, although we think of permafrost as cold, it is not too cold when you get down deep. It is only 1 or 2, or maybe 3, degrees below freezing.

When the frost goes down, you may have a temperature 5 feet above the surface along about April or May of minus 15° or 20°. If you put your pipes down to 10 or 11 or 12 feet, you get below the seasonal frostline. If you will keep an adequate flow of sewage or water through the pipe, you can do much to help.

So we feel that good engineering design, plus a few unique features, will probably solve many of the problems, with resultant saving, in the case of military construction, to the Government and, in the case of private construction, to the individual.

That type of work, we feel, is essential to really develop the vast resources of our low-temperature areas.

Mr. FOGARTY. That is all.

Mr. BUSBEY. Thank you, Doctor. The committee will stand adjourned.

THURSDAY, MARCH 26, 1953.

GRANTS FOR HOSPITAL CONSTRUCTION

WITNESSES

DR. JOHN W. CRONIN, CHIEF, DIVISION OF HOSPITAL FACILITIES
DR. JOHN McGIBONY, CHIEF, DIVISION OF HOSPITAL FACILITIES
CHARLES HILSENROTH, EXECUTIVE ASSISTANT, DIVISION OF HOSPITAL FACILITIES
GEORGE WILSON, BUREAU OF MEDICAL SERVICES
DR. VANE M. HOGE, ACTING CHIEF, BUREAU OF MEDICAL SERVICES

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$82,500,000	$75,000,000	$75,000,000
Prior year balance available:			
Appropriation		27,597,286	20,000,000
Contract authorization	34,080,943		
Total available for obligation	116,580,943	102,597,286	95,000,000
Balance available in subsequent year (appropriation)	−27,597,286	−20,000,000	−20,000,000
Unobligated balance, estimated savings (contract authorization)	−231,003		
	88,752,654	82,597,286	75,000,000

Obligations by activities

Grants for hospital construction:	
1952	$88,752,654
1953	$82,597,286
1954	$75,000,000

Obligations by objects

11	Grants, subsidies, and contributions:	
	1952	$88,752,654
	1953	82,597,286
	1954	75,000,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$151,179,922	$126,085,381	$105,479,667
Obligations incurred during the year	88,752,654	82,597,286	75,000,000
	239,932,576	208,682,667	180,479,667
Deduct:			
Unliquidated obligations, end of year	126,085,381	105,479,667	92,675,667
Obligations transferred to "Grants for hospital construction (liquidation of contract authorization), Public Health Service"	100,000,000	59,700,000	19,804,000
Total expenditures	13,847,195	43,503,000	68,000,000
Expenditures are distributed as follows:			
Out of current authorizations	13,847,195	43,503,000	68,000,000
Out of prior authorizations			

Mr. BUSBEY. The committee will come to order. We have under consideration the appropriation request for fiscal year 1954 for grants for hospital construction. Dr. Cronin, I believe you have a prepared statement. We shall be glad to hear it at this time.

Dr. CRONIN. Thank you, Mr. Chairman.

GENERAL STATEMENT

Mr. Chairman and members of the committee, the Hospital Survey and Construction Act, Public Law 725, 79th Congress, was enacted in August 1946. The program which has developed under the authority of this act is popularly known as the Hill-Burton program. The basic act was amended in October 1949 by Public Law 380, 81st Congress. Both acts amend Public Law 410, 78th Congress, which is the Public Health Service Act.

The purpose of the Hospital Survey and Construction Act, as amended, is to assist the States to provide "adequate hospital, clinic, and similar services to all their people." This is accomplished in two successive steps, namely, the survey and planning phase, which is a continuing program activity; and, financial assistance with Federal funds on a matching basis for the construction of hospitals, public-health centers, and related facilities.

The States, in carrying out their responsibilities, under the act, maintain a continuing inventory of their hospitals and annually revise their overall programs or so-called State plans. These State plans are a requirement of the law, as are the annual revisions. Approval by the Surgeon General of the Public Health Service of the State plan and the annual revisions entitle the States to participate in the annual appropriations by the Congress for the construction phase of the program.

The Federal funds which are appropriated are allocated to the States on the basis of a statutory mathematical formula the controlling factors of which are population and per-capita income. The amount authorized in the basic law for appropriation annually is $150 million. The amount actually appropriated each year rests with the Congress. Although the annual allocation to each State results from the application of the statutory formula to the funds appropriated, the States individually determine the amount of Federal funds to be made available to each project sponsor. This amount

varies from State to State and extends from a minimum of one-third to a maximum of two-thirds. The balance of construction money represents the State and local funds utilized in the matching arrangement. Actual Federal payments for construction are made in installments as construction of the project reaches various stages. The first installment is usually made after 25 percent of the project has been completed. Additional installments are made upon request and certification by the State that the project construction is in accordance with the basic contract documents signed by the sponsor and representatives of the State and the Federal Government.

TOTAL APPROPRIATIONS

In the 6 years of the program's operation the Congress has authorized a total of $542,500,000 for the construction phase of the program. All of these funds have been allocated to the States. Chart I indicates how this money is being utilized. It is significant to note that, as of January 1, 1953, $513 million in Federal funds has been matched by $1,045,000,000 in State and local money. This is slightly better than a 2-to-1 ratio. The combined Federal and State and local funds currently add up to a program of $1,558,000,000.

Altogether 1,980 projects have been approved. Of these, the 1,473 general hospitals represent the greatest majority. Of the nearly 2,000 projects, 1,100 are completed, open, and rendering a community service. There are 700 under construction, and the remaining are in the planning and drawing board stages. These projects are adding 96,500 hospital beds and over 330 public-health centers and related facilities to our health resources. It is very significant to note that 430 communities now have hospitals for the first time; 151 more now have hospitals where previously their so-called hospitals were substandard and unacceptable under the minimum laws regarding fire and life safety. Fifty-nine percent of the projects are compeltely new facilities, 41 percent are additions, alterations or expansion of existing facilities.

Of the new facilities, 59 percent are in communities of 5,000 or less in population and only 7 percent are located in cities which exceed 50,000 people. These 469 projects in the smaller communities may well serve in times of catastrophe in urban areas as evacuation destinations. On the other hand, nearly 170 larger projects, such as teaching hospitals approved for interne and residency training are utilizing $91 million of the total Federal funds made available to date. Similarly, 21 teaching facilities at university medical centers in 18 States have been allocated over $23 million. The program, therefore, is not overlooking the needs of the larger institutions in their vital role of training physicians, nurses, and other health personnel for eventual utilization in staffing the small hospitals and health centers. There remains much to be done in this area, but the Hill-Burton program is helping to a slight degree.

To measure the program accomplishments only in terms of number of buildings or numbers of beds provided does not entirely reflect its achievements. It would be much more satisfactory if we could express accomplishments in terms of furnishing adeqaute modern hospital care to many millions of people living in predominately rural areas. One of the reasons for the inception of the program was the fact that

physicians were not remaining in or going to rural areas and preferred the urban centers of population. Modern and efficient hospitals built under the Hill-Burton program have not only retained physicians in rural communities but also have attracted additional physicians. For example, a survey was made in 6 Southeastern States of 56 Hill-Burton hospitals which had been in operation 1 year or more. It was found that 156 general medical practitioners, surgeons, and specialists had been attracted to 47 of these 56 communities. Similarly, projects built under the program have been able to attract professional personnel, particularly nurses, out of retirement and afforded them the opportunity to practice their profession in hospitals in their own communities. In 1 Southwestern State 21 percent of the nurse personnel on the staffs of 21 Hill-Burton hospitals had returned from retirement status. We have been able to increase the total effective nurse supply. In addition, I know that adherence to sound architectural practices in the programing and design of functionally sound facilities is quite influential in providing better patient care throughout the country. In addition, an increasing number of small hospitals are now making provisions for consultative services in such fields as pathology, X-ray, and other diagnostic services. Other coopeartive relationships in the areas of administration, purchasing, pharmacy, dietetics, and graduate training, among others, will increase as time passes and recogintion of the need become apparent.

The foregoing is a brief picture of what this Federal, State, and local cooperative endeavor in the hospital survey and construction field has been able to achieve in 6 years. It is quite proper to examine the need for an appropriation in fiscal year 1954 to continue this program. The requested amount is $75 million. This is one-half of the annual amount authorized in the basic law.

When the States made their original surveys, as required by the Hill-Burton Act, and developed their original State plans, the Nation had approximately 868,000 existing acceptable hospital beds, exclusive of Federal beds, and a deficiency of over 900,000 beds. While the current program has been able to assist in providing 96,500 beds and while a substantial amount of hospital construction has taken place without Federal financial aid, the needs for beds have increased commensurate with population increases. Chart 2 shows our present status. Current State plan revisions indicate that our total hospital-bed need approaches the 2-million mark. We have approximately 1,057,000 acceptable beds and a deficiency of 850,000 beds. Even when one takes into consideration the existence of about 117,000 Federal hospital beds serving a civilian population such as those administered by the Veterans' Administration, the Indian Service, and the Public Health Service, our national bed deficiency still remains 733,000. In other words, with a substantial progress in total hospital-bed construction during the past 6 years (Federal aided and nonaided, about 190,000 beds) we are still faced with a tremendous hospital-bed deficiency. The bulk of this deficiency had accumulated during the depression years of 1929–39 when money was not available; and from 1939 to 1946 when basic construction materials were utilized for armament needed to prosecute World War II.

In terms of percentages, in 1948, 41 percent of our general hospital-bed needs were unmet. This was reduced to less than 33 percent in 1952. However, two-thirds of our national bed deficit is accounted for by the need to provide beds for patients with mental and long-term illnesses. As we begin to more nearly satisfy the needs for general hospital beds, increasing emphasis must be given to the needs in the other bed categories, i. e., tuberculosis, mental, and chronic. A series of 4 maps illustrates, better than words perhaps, the percentage of unmet bed needs in all 4 of the hospital-bed categories. For example, the relatively small unmet bed needs in the tuberculosis category is in contrast to the needs in the mental and chronic disease areas.

It is pertinent to indicate the extent to which an appropriation in fiscal year 1954 can assist the Nation. The average cost per hospital bed today is $16,000. The annual increase in population (2-million-plus) last year and the attrition and obsolescence of our existing hospital plant requires 30,000 beds annually. To meet these factors alone would require $480 million from all sources in 1954 and yet no inroads would be made on our accumulated deficit of over 733,000 beds, even taking into consideration the Federal beds serving civilians.

The $75 million requested, therefore, will at least help the Nation in maintaining its present level with respect to hospital beds. That sum will at least furnish an amount of assistance to States and project sponsors so as to help insure against any further increase in our hospital-bed deficit. This is regarded as very important, since our accumulated deficit is so great.

As has been mentioned, the role of the vast majority of the projects under Hill-Burton program, being located in communities of less than 5,000 population, in times of catastrophe in the urban areas cannot be overlooked. These small hospitals, removed from potential target areas may serve readily as evacuation destinations for the urban areas and as such will be greatly needed.

In conclusion, the Hill-Burton program is serving the Nation as a cooperative Federal, State, and local endeavor and warrants continuation so that our overall national hospital plant may be better able to meet the needs of our people in peace as well as in any form of disaster.

Mr. BUSBEY. I wish to apologize to you gentlemen for running a little late today. We expected that we would start right after lunch on this hospital-construction program, but it did not work out that way. I suggest that the committee adjourn at this time to meet at 10 o'clock tomorrow. We will start our interrogations at that time.

FRIDAY, MARCH 27, 1953.

SURVEY AND PLANNING

Mr. BUSBEY. The committee will come to order.

Yesterday, when we adjourned, Dr. Cronin had just finished presenting his prepared statement to the committee.

Dr. Cronin, on page 1 of your statement, at about the middle of the first paragraph, you refer to the two successive stages; the first is the survey and planning phase, which is a continuing program activ-

ity. How much of that cost is borne by the Federal Government and how much by the State and local interests?

Dr. CRONIN. Mr. Chairman, when the act was first passed it provided authorization for $3 million, which sum of money was to be appropriated and allotted to the States on the basis that the States would raise $2 for every $1 of Federal money. This money was to be used to survey the needs of the States in regard to hospitals and related health facilities. Each of the States had to look into its legislative authority, and they all passed legislative authority for them to appropriate money for this purpose to be matched with the Federal money.

Now, all of that $3 million has not been appropriated. That was an authorization. There has been $1.8 million appropriated, and there is a balance of $1.2 million authorized but not as yet appropriated.

We are not presenting this year any request for this survey money because that was not successfully passed through Bureau of the Budget level.

Some of the States are in a position where they want money for survey and planning, and some of the States are not requesting money for survey and planning.

RFC LOANS

Mr. BUSBEY. On page 2 you refer to the fact that, as of January 1, 1953, $513 million in Federal funds has been matched by $1,045,000,000 in State and local money. As I listened to you yesterday, I wondered if by any chance some of that local money might have been from RFC loans.

Dr. CRONIN. As far as I know, none of that is RFC loans. The reason I hesitate in answering, Mr. Chairman, is this: that the RFC, under its authorization and administrative policies, in my understanding, did not lend money to nonprofit hospitals. The Hill-Burton program requires that a project to receive money must be a nonprofit hospital.

Now, when the civil-defense activities came into the picture the Civil Defense Administration is permitted to assist, working with the RFC. Let us put it the other way around: The RFC can lend money to a hospital for the purpose of making that hospital more usable or perhaps more available if we ran into a national catastrophe and if that particular hospital project was in a position of great or potential damage from any kind of catastrophe resulting from war and so on.

The RFC requires that Civil Defense indicate to them that this project is of that order. Under those circumstances the RFC law was so written that they could lend money to nonprofit hospitals.

Now, as far as we know, no hospital which is receiving Hill-Burton money at the present time is receiving RFC money.

I would like to point out that the Hill-Burton money is a grant, whereas the RFC money is a loan.

DETERMINATION OF STANDARDS

Mr. BUSBEY. Starting with the last three words on page 2, and continuing on page 3, I quote the following:

> It is very significant to note that 430 communities now have hospitals for the first time; 151 more now have hospitals where previously their so-called hospitals were substandard and unacceptable under the minimum laws regarding fire and life safety.

Who makes the determination as to whether they are substandard or unacceptable? Do you make that determination or do the States make that determination?

Dr. CRONIN. The States make that determination.

Mr. BUSBEY. That determination is made entirely by the States?

Dr. CRONIN. In this way, Mr. Chairman: that a hospital, in order to operate as a hospital in the respective States, must be acceptable to that State as a health-care facility. Some States have very specific licensing laws on that. In other States licensing laws and standards are quite broad.

What we have reference to there is that there are 430 communities now that have hospitals approved under the Hill-Burton Act. In other words, hospitals built with financial assistance under the act at their own request, where they never had a hospital before.

No. 2, these 151 more that we refer to are hospitals which have been built in towns where the only hospital facility in that town was of the type such as a physician's home, which was built as a residence for people to live in. The physician had either purchased it to live in himself and, on the second floor or perhaps the parlor or music room, he had converted it to have 2 or 3 beds, in which he kept patients; and he ran a hospital of his own there. Those buildings that were built as residence homes, under most of the laws concerning fire and life safety, are not fireproof buildings.

They can even be a brick building, with a wooden floor, but that still does not meet the standards for public buildings and so on. These 151 have been replaced by new, modern, fireproof hospitals.

TEACHING FACILITIES

Mr. BUSBEY. Further down in the middle of the next paragraph you state:

> Similarly, 21 teaching facilities at university medical centers in 18 States have been allocated over $23 million.

Would you, for the benefit of the committee, tell us what that program involves?

Dr. CRONIN. That is part of the overall program as we conduct it under the Hill-Burton Act. As you know, the Federal money is given to the States on the basis of per capita income and population, as is defined in the law. The States, in turn, are required by the law to set up a priority system of giving that money to projects within the State.

That priority system is based on the need for hospital services in the various communities of the State, with the highest priority being given the areas that have the greatest amount of unmet bed need; in other words, the greatest need for hospital beds.

However, States have authority to set up special priorities if that project is going to serve a very useful and necessary service in the State. One of those special priority areas is an area in which the hospital or project is a teaching hospital. In other words, a hospital where people are trained to carry out their various professions in the health areas—nurses, dentists, pharmacists, X-ray technicians, lab technicians, and so forth. That project will be given a special priority within the general hospital priority picture.

It is under that category of priority that the States in 21 instances, at the university medical teaching centers, have been assisting through Hill-Burton money in the construction of various projects. Some of those projects are full-scale hospitals, a total hospital such as a university medical school hospital, with all the various facilities there.

However, I should mention that in the hospital any of the facilities which are strictly teaching facilities or educational, which could be related to the teaching curriculum of the the medical school, are not eligible under the Hill-Burton Act because it was not designed to participate in the educational area per se. Some of these projects are in that category.

Other projects are not total hospitals, but could be, for example, a psychiatric unit associated with that particular hospital. It could be an alteration and revision and modernization, perhaps, of their surgical unit or even facilities for obstetrics and nurseries and so on. Those, in these teaching facilities that we have singled out as large teaching facilities, in 18 States, are where $23 million has gone out of the $542 million which has been appropriated.

I also might indicate there that over 120 teaching institutions have received Federal money. But those teaching institutions are of varying sizes. They are part of the total program because we feel that it is not only proper that the small hospitals be built where they are needed, but also that something be done to help the institutions that are going to turn out the people to staff those small hospitals; that their facilities should be added so they can do so. That is concurred with.

It is not only our idea at the Federal level. I would like to emphasize now that we at the Federal level do not have the only ideas on this program. This program is the outstanding example, in my opinion, of a very cooperative endeavor by the States, Federal Government, and local communities. No project under this program is built because some Federal official thinks it should be or because some State official thinks it should be. It has to be in the State plan in each State and it has to be concurred in by the people of the community where the hospital is built.

ALLOTMENT FORMULA

Mr. BUSBEY. You were discussing the formula for the allocation of funds provided by the law. Briefly, what is that formula?

Dr. CRONIN. What I have reference to, Mr. Chairman, is that in the act there is a statement that the method in which the amount of money appropriated by Congress should be allotted to the States is to be based on a mathematical formula. That mathematical formula is a complicated formula. However, I think it suffices to say that the two factors that control the money which is allotted to the States are the factors of population of the State and the per capita income of the State, as a measure of the wealth of the State.

For example, I could cite the case of A State, which has the same population as B State, but A State being a State that has a low per capita income and B State being a State with a high per capita income. The State that gets the least amount of money would be the State that has the high population and the high per capita income. The State that gets the most amount of money would be the State that has the high population and the low per capita income.

Mr. BUSBEY. That is the same reason that most of the Southern States get the bulk of the money under these grant programs, not only under the Hill-Burton Act but also under the other grant programs administered by the Federal Government.

Dr. CRONIN. Mr. Chairman, I am not an authority on the other grant programs, but I can speak for the Hill-Burton program.

In the Hill-Burton program the Southern States, because of their high population and low per capita income, have received a higher percentage of money than some of the other areas of the country. I do not think it is quite right to say that they have received the bulk of the money, because there are States certainly not classified as Southern States that are receiving a considerable portion of the money each year under this program.

Mr. BUSBEY. Would you say that under that formula many of the Southern States get a distinct benefit due to the low wage scale of the colored population?

Dr. CRONIN. No, Mr. Chairman; I would not say that because, if I remember correctly, at the time this bill was discussed in the committee, at the time of the hearings, Senator Robert Taft, of Ohio, practically rewrote this bill. Senator Taft's intention at that time, as he stated, was to make as near as possible a grant program—although in essence this is not a grant program in the true sense of the word, but is a payment program for services rendered—that would have equity in it more than any other program that was then in existence. This program does have a factor of equity in it in that the distribution of the money to the States on the allotment formula differs somewhat from other grant programs. As a result, at least it is my feeling that at the present time this is as equitable a way as one could allot money throughout the country without penalizing any one group or helping any other group.

I know of no other way to do it than the way it is being done at the present time. That does not mean there is not another way, but I just do not know of it.

ESTABLISHMENT OF PRIORITIES THROUGH STATE SURVEY

Mr. BUSBEY. Will you explain how these priorities are set up in the States, and what the different factors are.

Dr. CRONIN. Yes, sir. According to the basic law, which is Public Law 725 of the 79th Congress, before any construction money is allotted to the State and any project in the State can participate in this program, the State must survey its needs and the survey and planning money, as I explained before—$1 Federal and $2 State—became available and the State then surveyed its need. Roughly they did this: They divided the State into geographical areas and they called those geographical areas "hospital service areas." That hos-

pital service area geographically could have been a county, or two counties, or half a county, or whatever, in exercising their discretion that particular State agency decided it to be.

The law says that the Hill-Burton money will not be used to exceed the ceiling of providing more than 4½ beds per 1,000 people, roughly, for general hospitals; 5 beds per 1,000 people for mental hospitals; 2 beds per 1,000 people for chronic-disease hospitals; and 2½ beds for average annual deaths from tuberculosis over a sample 5-year period, 1939 to 1944, or any subsequent 5-year grouping for tuberculosis hospitals.

Now, when a State knows how many people live in a hospital service area and knows how many beds are in that hospital service area in the four categories described, they then can arrive at a priority system of the hospital service area over another hospital service area.

The law requires that the money allotted to the States be given to the area that has the greatest unmet bed need. The other side of that coin would be the area that has the greatest need for hospital service. It is based on their findings in the State survey.

STATE ADVISORY COUNCIL

This State survey is reviewed by a State advisory council, which is appointed by the governor of the State, and that State advisory council, as is the Federal Hospital Council, is made up of two kinds of folks. One group is of those individuals who represent the health profession—doctors, nurses, pharmacists, sanitary engineers, and so on. The other groups is a group which represents the consumer public; and those are leaders in the agricultural field, the labor field, the educational field, the clergy interests in the State, and the merchant interests.

In the States these advisory councils to the State agency review these State plans and advise the State agency concerning them, and certainly represent their interests in seeing the planning for hospital construction in the State. Now, those State plans are required by law to be approved by the Surgeon General of the Public Health Service, and they are. It is also noteworthy to state that those State plans are also by law required to be revised each year, and they are.

It is upon approval of those State plans and submission of the State's construction schedule with the names of the projects on that schedule, certified by the State that no project is on that schedule which is jeopardizing another project in the State of higher priority, which is in a position and desires to go ahead and construct a hospital, that this program basically operates.

CALIFORNIA

Mr. BUSBEY. Let us take the case of California. I have a table here which shows the approved projects by priority area for each of the fiscal years 1948 through 1953. This shows that out of a grand total of $15,320,109 only $2,011,269 went into areas where there was what might be termed 100 percent need; o$4,991,710 went into areas where 1 to 25 percent of the need had been met; $6,074,487 went into areas where there was 25 to 50 percent of the need had been met; and $2,242,643 went into areas where over 50% of the need had already been met.

You have that table before you; do you not?

Dr. CRONIN. Yes, sir.

Mr. BUSBEY. Would you say in that case that the funds went to the area which had the greatest need?

Dr. CRONIN. Mr. Busbey, my statement on that would be this: That the State of California under the terms of the act has the discretion in drawing up their State plan to place the money allotted to them under the Hill-Burton program in the area where they in California think that money will do the most good. Under the act the allotting of the money from the State level to the communities that have the greatest amount of need does not basically insure that the areas that have the greatest amount of need can come up with their matching local funds together with the money that has been given to the State.

That, I think, was best illustrated when on October 25, 1949, the Congress of the United States modified or amended this law and said that because there were a number of areas in the United States that were unable to come up with a two-thirds local and/or State money to match the mandatory one-third, which was the law at that time, of Federal money, that the law should be amended. The law was amended to permit the States to set the Federal percentage, as it was indicated and needed in their States, within certain limits. So that to look at a table and say that the money is not going to the area of greatest need must be tempered with the statement that the money is able to go to the area with the greatest need if the area with the greatest need can match in accordance with the provisions of law its share of the money.

In many areas of the country we will find that the area that has the highest priority is financially unable, perhaps, to match Federal money, and there are some areas of this country where the area with the highest priority is not interested in matching Federal money. In other words, they do not want Federal money. That, to me, is their prerogative and right to decide.

Mr. BUSBEY. It seems to me that at the least this kind of thing has a tendency to defeat the basic purpose of the law, because the original intent was to try to put these hospitals in the areas which had the greatest need. Under this system just discussed, if one community or area cannot raise the required amount of matching funds, the area that is well off and has the funds can take advantage of the situation.

Dr. CRONIN. Mr. Chairman, that is not entirely applicable to the whole thing for this reason: That, also, at the time the law was amended on October 25, 1949, the Congress again said to the States—I am sure based on your statement this time—that the States have the right to elect to take either a flat rate for every project in the State in any one year or to elect to take a variable scale of Federal participation based on certain relevant factors to the case such as you have explained: Inability to raise sufficient money to match established Federal shares, if it is fixed at some level. And it permitted the States to say:

> We will take a variable percentage of Federal participation and we will then consider what is the economic status of the areas within our State in trying to match the Federal money in getting a hopsital.

What are the factors in the State relative to the need for the hospital in an area? Now, a number of the States have used and are

using quite successfully the variable scale. Those are usually the States that have these problems of areas of their State economically being less rich than other areas of the State. In that way the goals of the program are being able to be met.

I would also like to point out, too, that the percentage of need met in California is an example that there is no uniform way across the country in the several States of establishing A priority or B priority or C priority or D priority and so on. The priority establishment in some States—perhaps California is one of those; I know it is—is such that the A priority area is the geographical area of the State that has zero percentage of need met; the B priority is the area with up to 21 percent of the need met; the C priority is up to 50 percent.

California also introduces another factor. That is the point system that they use, which gives consideration to the mileage between hospitals. Under that situation the priority of an area is determined frequently or influenced frequently by the mileage between hospitals in that area so far as getting Federal money is concerned. If it is 5 miles between 2 cities and the roads are good, with no obstructions in the way, such as mountains and rivers and so on, that definitely will influence in the State of California the priority of that project in getting a hospital as distinguished from another area were you might have geographical blockings such as mountains.

FEDERAL APPROVAL OF STATE PROJECT SCHEDULES

Mr. BUSBEY. After you have turned the allotment or entitlement of money under the Hill-Burton program over to the State agency, do you have any jurisdiction over its project allocation?

Dr. CRONIN. The Federal Government has no jurisdiction as to where the State will elect to put the money so far as the project is concerned. However, the Federal Government, by virtue of the act, has the obligation and responsibility of approving the State plan. When the State submits its project-construction schedule the State is required to certify to the Federal Government that the placing of a project on that construction schedule is not jepordizing the position of any project with a higher priority in that State that is ready to go ahead and consruct.

Mr. BUSBEY. When you say "approving the plan" do you mean the approving of the architect's plan for the hospital, or does that approval cover all of the general plans?

Dr. CRONIN. I think, Mr. Chairman, you have reference to my statement concerning the approving of the State plan.

Mr. BUSBEY. Yes.

Dr. CRONIN. The State plan is the overall program of that State with reference to their need for hospital and health facilities in the State, and demonstrating every hospital and health facility in the State in the State plan. That is what is required to be approved by the Surgeon General.

If I may suggest, I think what you have reference to indirectly is: Does the Federal Government have to approve the design and general plans for these hospitals? That is another part of the program, but the design of these hospitals is the obligation of the architect that is hired by the sponsor. That architect is not a Federal architect, nor is

he a State architect unless the project happens to be a State institution, such as a State tuberculosis sanitarium or a State mental institution.

The project is drawn schematically, as we call it, by the architect hired by the sponsor. That drawing is submitted along with other required programs regarding that particular project first to the State agency. The State agency reviews the overall project, considers the design of the project, considers the financial arrangements that that community is going to use to comply with the law, considers whether or not that project meets the fire codes of the State, whether it meets the building codes of the State, whether it meets the license regulations concerning obstetrical cases and child nurseries, and so on.

Mr. BUSBEY. Are the States not able to do most of that?

Dr. CRONIN. They do that. That is the State's responsibility entirely. The Federal Government has not come into this picture yet.

Mr. BUSBEY. I see.

Dr. CRONIN. After the State has done all of that and approved the project, the project then is sent to our regional office. Our regional office staff reviews the project to determine, first, did the State approve the project in direct relationship to the law, so far as the priority of the project was concerned? Second, did the State approve the project and give proper consideration to seeing that the project construction and design meet the minimum standards as required by the Federal Government?

I would like to emphasize that the Federal Government sets only minimum standards, such things as that no door to a patient's room in a hospital can be less than 44 inches wide, because if a patient is in bed in that room and a fire breaks out, and the patient is unable to get out of bed, the bed can be wheeled through a door 44 inches wide, because the average hospital bed is around 37 inches wide. If that door were 35 inches wide it would mean there would be a possibility of that patient's life being in danger.

That is the role of the Federal Government, to check to see that the State in approving the project is adhering to the minimum standards set by the law.

STATE PROJECT ALLOCATION OF FEDERAL FUNDS

Mr. BUSBEY. What happens, for instance, if you approve a project for $1 million in a State and then the State changes its mind? Can it spend that money someplace else without your approval?

Dr. CRONIN. I do not quite understand your question.

Mr. BUSBEY. You have allotted $1 million to State A.

Dr. CRONIN. We give the total amount of money to the State the 1st of July each year, after it becomes available.

Mr. BUSBEY. Yes.

Dr. CRONIN. The State in turn allots the money to a project. It says: "We will approve your project for X amount of money based on what you have shown us you need and we agree to."

Mr. BUSBEY. Does the Federal Government not reserve any veto power over this at all?

Dr. CRONIN. If the State in carrying out the program approves the project, and the project is eligible under the provisions of law, the Federal Government will approve that project.

Mr. BUSBEY. The State can spend it anywhere it wants, so long as it is eligible under the law?

Dr. CRONIN. Under the provisions of law, yes, sir. They can place that project anywhere in the State. But the provisions of law very specifically set minimum requirements on that State about the placement of that project.

ALLOCATIONS OF FUNDS BY PRIORITY AREAS

Mr. BUSBEY. In order to condense the hearings and save the time of the committee, would you furnish for the record not only the table I was referring to for California, but also similar tables for Alabama, Colorado, Georgia, Montana, South Carolina, Tennessee, and Washington?

Show the total in each of the four categories of need, along with the grand total that has been appropriated and allotted under this act to the States.

Dr. CRONIN. We would be glad to do that, Mr. Chairman.

(The information is as follows:)

Federal share allotted in Alabama projects, by priority area, by fiscal year of approval

[Priority in terms of hospital areas, percent of need met]

	0	1 to 25	25 to 50	50 and over
1948		$1,353,147		$1,387,705
1949	$2,982,872	439,241	$4,781,509	
1950	1,145,846			664,361
1951	1,759,704		346,987	
1952		253,318	375,623	246,612
1953	500,000			597,904
Total	6,388,422	2,045,706	5,504,119	2,896,582
Grand total		16,834,829		

Federal share allotted in California projects, by priority area, by fiscal year of approval

[Priority in terms of hospital areas percent of need met]

	0	1 to 25	25 to 50	30 and over
1948	491,598	1,054,098	233,674	346,315
1949	1,005,177	947,980	416,248	
1950	417,937		2,839,756	1,252,420
1951		913,282	1,647,328	89,672
1952			937,481	554,236
1953	96,557	2,076,350		
Total	2,011,269	4,991,710	6,074,487	2,242,643
Grand total		15,320,109		

Federal share allotted in Colorado to projects, by priority area, by fiscal year of approval

[Priority in terms of hospital areas percent of need met]

	0	1 to 25	25 to 50	50 and over
1948		217,066	753,981	
1949 and 1950	108,392		435,863	1,179,254
1951		387,764		
1952				752,240
1953				
Total	108,392	604,830	1,189,844	1,931,494
Grand total		3,834,350		

Federal share allotted in Georgia to projects, by priority area, by fiscal year of approval

[Priority in terms of hospital areas percent of need met]

	0	1 to 25	25 to 50	50 and over
1948	507,750		2,140,253	473,664
1949	594,017	116,280	1,777,739	
1950	198,000	154,318	4,398,371	99,555
1951	609,986		1,500,374	460,667
1952			2,531,624	95,401
Total	1,909,753	270,598	12,348,361	1,129,287
Grand total	15,657,999			

Federal share allotted in Montana to projects, by priority area, by fiscal year of approval

[Priority in terms of hospital areas percent of need met]

	0	1 to 25	25 to 50	50 and over
1948	222,890			55,414
1949	219,371			111,689
1950	208,779		155,594	
1951	30,903			211,739
1952		269,632	122,995	
Total	681,943	269,632	278,589	378,842
Grand total	1,609,006			

Federal share allotted in South Carolina to projects, by priority area, by fiscal year of approval

[Priority in terms of hospital areas percent need met]

	0	1 to 25	25 to 50	50 and over
1948	457,178	120,010	908,580	180,368
1949	328,024		581,656	1,999,361
1950	1,003,875			747,214
1951				5,985,504
1952	542,913			39,754
Total	2,331,990	120,010	1,490,236	8,952,201
Grand total	12,894,437			

Federal share allotted in Tennessee to projects, by priority area, by fiscal year of approval

[Priority in terms of hospital areas percent of need met]

	0	1 to 25	25 to 50	50 and over
1948		676,144	1,231,054	600,795
1949	405,158		673,033	517,063
1950			2,522,312	1,002,028
1951				
1952			1,467,570	223,200
1953			52,000	
Total	405,158	676,144	5,945,969	2,343,086
Grand total	9,370,357			

Federal share allotted in Washington to projects, by priority area, by fiscal year of approval

[Priority in terms of hospital areas percent of need met]

	0	1 to 25	25 to 50	50 and over
1948	214,175			431,706
1949				467,166
1950	508,024		299,242	1,050,697
1951		92,800	634,225	678,460
1952				844,400
1953				359,000
Total	722,199	92,800	933,467	3,831,429
Grand total		5,579,895		

Allotments to the States and Territories

State or Territory	1948	1949	1950	1951	1952	1953	Cumulative total
Total	$75,000,000	$75,000,000	$150,000,000	$85,000,000	$82,500,000	$75,000,000	$542,500,000
Alabama	2,885,880	2,690,543	5,140,275	2,901,596	3,014,588	2,674,162	19,307,044
Arizona	451,739	443,109	852,521	481,233	483,702	463,728	3,176,032
Arkansas	1,966,582	1,966,552	3,776,391	2,131,707	1,885,430	1,685,566	13,412,228
California	1,956,160	2,121,367	5,147,909	2,905,905	2,758,014	2,565,659	17,455,014
Colorado	656,652	635,878	1,022,875	577,395	581,476	539,688	4,013,964
Connecticut	421,523	422,222	1,016,289	573,677	621,996	564,189	3,619,896
Delaware	100,000	100,000	200,000	200,000	200,000	200,000	1,000,000
District of Columbia	298,110	275,268	490,555	276,910	204,735	200,000	1,745,578
Florida	1,460,260	1,481,446	2,895,128	1,634,249	1,893,140	1,806,581	11,170,804
Georgia	2,976,228	2,791,307	5,248,356	2,962,605	3,068,889	2,774,251	19,821,636
Idaho	293,162	300,347	627,378	354,144	324,984	291,180	2,191,195
Illinois	2,768,690	2,764,357	4,723,670	2,666,429	2,695,593	2,438,910	18,057,649
Indiana	1,726,355	1,754,093	3,838,365	2,166,690	2,034,798	1,865,636	13,385,937
Iowa	1,340,446	1,393,932	3,051,411	1,722,468	1,346,525	1,205,231	10,060,013
Kansas	932,719	972,758	2,044,104	1,153,861	1,081,829	989,639	7,174,910
Kentucky	2,587,095	2,560,957	4,933,095	2,784,646	2,685,339	2,379,780	17,930,912
Louisiana	2,154,850	2,099,507	4,239,701	2,393,237	2,251,098	2,066,930	15,205,323
Maine	454,438	467,139	1,069,132	603,506	621,258	541,997	3,757,470
Maryland	869,663	827,301	1,585,285	894,866	1,020,721	950,170	6,148,006
Massachusetts	1,593,795	1,622,561	3,312,332	1,869,754	2,061,948	1,859,157	12,319,547
Michigan	2,169,996	2,174,668	5,134,736	2,898,469	2,662,947	2,444,644	17,485,460
Minnesota	1,653,926	1,725,122	3,414,126	1,927,214	1,674,461	1,502,369	11,897,218
Mississippi	2,401,451	2,270,043	4,469,485	2,522,946	2,404,732	2,161,135	16,229,792
Missouri	2,280,213	2,293,924	4,340,297	2,450,022	2,186,873	1,997,746	15,549,075
Montana	231,530	224,137	345,499	200,000	207,113	200,000	1,408,279
Nebraska	684,394	682,443	1,367,926	772,170	668,669	607,828	4,783,430
Nevada		100,000	200,000	200,000	200,000	200,000	900,000
New Hampshire	342,122	367,648	636,060	359,048	324,081	289,988	2,318,947
New Jersey	1,312,554	1,328,053	2,923,571	1,650,305	1,694,722	1,557,402	10,466,607
New Mexico	457,062	457,632	812,552	458,671	539,397	521,666	3,246,980
New York	2,941,663	3,029,743	5,942,049	3,354,183	3,575,887	3,237,309	22,080,834
North Carolina	3,429,016	3,413,486	6,414,042	3,620,615	3,715,001	3,379,249	23,971,409
North Dakota	308,157	287,845	473,041	267,023	264,285	230,635	1,830,986
Ohio	2,690,189	2,715,846	5,979,473	3,375,308	3,292,080	2,985,375	21,038,271
Oklahoma	1,639,006	1,730,437	3,683,879	2,079,485	1,708,338	1,548,466	12,389,611
Oregon	460,361	534,815	1,544,418	871,797	577,949	528,592	4,517,932
Pennsylvania	4,547,379	4,692,355	9,241,058	5,216,416	4,711,853	4,234,841	32,643,902
Rhode Island	279,966	267,856	522,590	294,993	357,383	319,776	2,042,564
South Carolina	1,974,755	1,923,581	3,693,309	2,084,809	2,080,814	1,865,785	13,623,053
South Dakota	359,217	353,873	585,912	330,737	315,141	279,264	2,224,144
Tennessee	2,671,070	2,616,055	4,977,256	2,809,574	2,954,710	2,661,875	18,690,540
Texas	4,836,567	4,865,137	9,494,344	5,359,392	5,011,244	4,640,780	34,207,464
Utah	364,840	354,023	754,320	425,801	415,457	381,661	2,696,102
Vermont	214,510	227,131	421,695	238,039	259,609	229,146	1,590,130
Virginia	2,208,159	2,114,928	4,062,611	2,293,273	2,446,564	2,230,318	15,355,853
Washington	511,646	553,979	1,834,829	1,035,729	1,020,065	929,243	5,885,491
West Virginia	1,554,281	1,529,058	2,787,048	1,573,240	1,524,191	1,355,066	10,322,884
Wisconsin	1,621,161	1,610,133	3,105,901	1,753,227	1,703,089	1,540,051	11,333,562
Wyoming	144,856	146,879	245,652	200,000	200,000	200,000	1,137,387
Alaska	100,000	100,000	200,000	200,000	200,000	200,000	1,000,000
Hawaii	222,758	261,868	500,884	282,740	249,930	222,220	1,740,400
Puerto Rico	2,460,083	2,327,387	4,619,631	2,607,701	2,487,331	2,228,307	16,730,440
Virgin Islands	32,765	29,271	57,034	32,195	30,021	26,809	208,095

Mr. STEPHENS. Mr. Chairman, you raised one question awhile ago that I do not believe has been completely answered yet.

I am not an authority on this, but with reference to the money going to the high-priority projects, by law, rather than to the other priority projects, the No. 1 project in a given State might be a little 50-bed hospital out in a rural area which would require less money than the No. 3 or No. 4 project in the same State, which would require more money if it were built at all. The No. 1 project as a matter of logic might require much less money than something further down the line.

Dr. CRONIN. In most instances that is true.

Mr. BUSBEY. Thank you for your contribution, Mr. Stephens.

Mr. STEPHENS. Thank you, Mr. Chairman.

ALLOTMENTS RELATED TO UNMET BED NEEDS

Mr. BUSBEY. How much of the Federal funds have gone into areas where the need was less than one-half met prior to the allotment of Hill-Burton funds?

Dr. CRONIN. Mr. Chairman, I would have to look that up.

Mr. BUSBEY. Supply it for the record, please.

Dr. CRONIN. We will do that.

(The information is as follows:)

Out of a total of $451,487,000 in Federal funds approved for general hospital construction, $299,823,000 represents projects where the unmet bed need in the area was less than 50 percent. One-third, or $151,554,000, represents projects where the unmet bed need was more than 50 percent.

BURLINGTON, COLO., HOSPITAL

Mr. BUSBEY. While we are speaking of allotments related to degree of need, I think this would be an appropriate time to refer to a situation in Colorado which I referred to in 1951. I am reading excerpts from the newspaper of Burlington, Colo., the Burlington Record, of Thursday, May 24, 1951:

Last week the Record received a letter from Congressman William S. Hill, asking for a detailed report on how money was raised for the construction of the Kit Carson County Memorial Hospital in Burlington. Mr. Hill's request came following a communication from Congressman Fred E. Busbey, of Illinois, whose Subcommittee on Appropriations has charge of all hospital appropriations under the Hill-Burton Act.

Mr. Busbey's attention was called to the fact that Kit Carson County had erected the memorial hospital without Federal aid through a mimeographed letter which was distributed to all Members of Congress the previous week * * * The letter the Congressman read follows:

"Gentlemen—follow this line of reasoning:

"The central evil in the United States today is the trend toward socialism, based on the belief that people can't solve their local problems. This trend is stopped many times temporarily on many fronts, only to advance in some other direction * * *.

"While there is this confusion by the policymakers, there is a small farm community of eastern Colorado that believes more in action than words. Burlington, Colo., with a population of only 1,280, and the farmers of Kit Carson County built without Federal, State, and only indirect county help, a modern hospital that would be a credit to a population many times that size. Farmers donating 10 acres of wheat apiece, or hauling supplies on return trips from Denver are only part of an amazing story in which this community took care of a local problem locally. Turning down even the 50–50 aid of the Hill-Burton

bill, the people were even set on putting a neon sign 'This hospital built entirely without Federal aid' on the hospital roof."

I think that is a very fine demonstration of the spirit that has built America and has made America what it is today.

EFFECT OF FEDERAL PROGRAM ON LOCAL INITIATIVE AND RESPONSIBILITY

Do you not think that programs such as this Hill-Burton program have a tendency to take some of that spirit out of the people, since they realize that they can come to the Federal Government and get funds?

Dr. CRONIN. Mr. Busbey, I am not an authority on Federal-State relationships. I understand there is a committee or a commission going into that matter. You have asked me a direct question. I would like to give you a direct answer.

I believe that in a democracy the job to be done is what the people of the country want to do and how they want to do it is to be determined by them. I think the Hill-Burton program, at least in my experience with it, which is now approximately 4 years, is a demonstration of how the Federal Government, the local community, and the State can get together in a cooperative endeavor to accomplish something which many areas of this country are unable to accomplish for themselves by themselves.

I offer in testimony the fact that this program, with its $542½ million appropriated by Congress for distribution to the States, has been matched by the people of this country to the extent of $1,045 million, so that the program today is a program of $1.5 billion of hospital construction. Even in the State of Colorado alone there are 17 communities which have built hospitals costing $10,419,000 and have accepted $3,875,000 from the Federal Government.

Now, I feel that if the community wishes to do it that way, that is the community's responsibility and the community's decision. Speaking through their elected Representatives in Congress they have the right to say what they want to do. I would, as a citizen of this country, go along with that decision.

Mr. BUSBEY. Of course I appreciate your position in this, which is to administer the funds under the law.

Dr. CRONIN. That is correct. I might add, Mr. Chairman, that this program, in my personal opinion, is probably one of the best defenses there is against any form of what we normally consider to be socialization in the medical area. I think that opinion is shared by the medical leaders of the country and by people of both political-party beliefs.

Mr. BUSBY. It may not be shared by the medical leaders of the country, but I do not mind putting on the record the fact that I have admonished some of the medical leaders of the country that I think building some of these private clinics, let alone building federally supported health centers, might lead toward socialized medicine some day. I have not hesitated to critize the medical leaders where I thought they needed criticism.

In Chicago, for instance, all through the community there are little clinics where doctors have gotten together, perhaps built a building, and they have their offices in these clinics. The people are getting in

the habit of going to a clinic center rather than to a doctor's private office. I think that the more the people get in a habit of going to a clinic center, whether it is built under the Hill-Burton Act or whether it is built privately by doctors, the more we move in the direction of the socialization of medicine.

APPROVAL OF SOUTHERN HEALTH CENTERS

Now, in the Southern States, what is the largest number of health centers approved in one county?

FULTON COUNTY, GA.

Dr. CRONIN. I think Fulton County, Ga., which is the area around Atlanta, is the area that has the greatest number of health centers approved.

Mr. BUSBEY. Do you have the figure on that?

Dr. CRONIN. We can look it up and supply it.

Mr. BUSBEY. All right, if you will, please supply it for the record.

(The information is as follows:)

HEALTH CENTER CONSTRUCTION IN FULTON COUNTY, GA.

Fulton County has an area of 523 square miles and a population of 473,572. The Georgia State plan provides for 2 public health centers and 16 auxiliary units in this county. To date, approved projects consist of 1 public health center* in the city of Atlanta and 13 auxiliary health centers in the smaller communities in Fulton County as follows:

Location	Total cost	Federal share
Adamsville	$43,001	$14,334
Alpharetta	37,654	12,551
Atlanta*	476,881	158,960
Buckhead	38,726	12,909
Center Hill	42,120	14,040
Collins	39,380	13,127
Fairburn	40,696	13,565
Howell Mill	31,679	10,560
Lakewood	37,935	12,645
Perkerson	38,190	12,730
Red Oak	42,086	14,029
Rockdale Park	32,901	10,967
Sandy Springs	36,271	12,090
South Fulton	33,111	11,037

It is the policy of the State of Georgia to allocate 12½ percent of the total funds available under the program for health-center construction. This amount is no more than adequate to provide a balance among the categories of facilities, as required by the regulations issued pursuant to the Hill-Burton Act. The comparatively large number of auxiliary health-center projects approved for Fulton County to date is due to the fact that the county was one of the few Georgia counties that had the necessary matching funds.

Mr. BUSBEY. As long as we have already mentioned Fulton County, Ga., do you know what the basis of determining the need in that instance was?

Dr. CRONIN. I would have to investigate that to give you a specific answer. However, I think I could comment on it.

I think the situation, knowing what I know about Atlanta and the environs of Atlanta, is based on the general philosophy that the modern medical commodity is really a fusion of curative medicine and

preventive medicine into health maintenance. That is the commodity that the people in that area are requesting.

The curative side of medical care is furnished in most instances by the physicians of the community and the hospitals of the community. These are both governmental and nongovernmental in origin. By the former, I mean State or county operated.

Now, the operation of public-health centers in most instances is a governmental activity. The facilities in nearly all instances are a State, city, or county governmental activity. That means that in the city of Atlanta and Fulton County rests the responsibility for building the centers, from which will emanate the mental-health programs, the tuberculosis-control programs, the venereal-disease-control programs, and other health-education programs; and all other programs relating to not what we properly call public health but what in essence could be called the health of the public—sanitary engineering programs and so on—come out of these public-health centers. As such, the people in that area, in desiring to furnish in reality a health-maintenance program for the people of that area to improve the health of the public of that area, have used the Hill-Burton money as it is able to be used under the law, to construct these public-health centers so that the preventive aspect of this whole picture, in this fusion I spoke about, can come up to and meet and serve the needs of the people as it should.

STATE AUTHORITY TO APPROVE HEALTH CENTERS

Mr. BUSBEY. Can a State agency approve as many health centers as it wants in any given area?

Dr. CRONIN. The State agency is limited to the approval of health centers by, again, the terms of the law, which says that a health center will serve 20,000 people to 30,000 people, depending upon population density.

SOURCES OF NURSING STAFFS

Mr. BUSBEY. On page 4 of your prepared statement, the seventh line from the top, you state:

> In one Southwestern State 21 percent of the nurse personnel on the staff of 21 Hill-Burton hospitals had returned from retirement status. We have been able to increase the total effective nurse supply.

How many nurses did you take away from existing hospitals which already had a shortage of nurses?

Dr. CRONIN. Mr. Chairman, I cannot answer that question because I do not know.

Mr. BUSBEY. Do you have any statistics or tables that would show how many nurses have been taken away from existing facilities to staff Hill-Burton hospitals?

Dr. CRONIN. We do not, because this survey was done by the State agency. Sir, that was the State of Texas.

We do not have adequate funds to carry on investigations under this appropriation to determine the staffing of these hospitals; but, because we are interested in it and because we are frequently asked

the question, arrangements were made with the State of Texas to investigate the situation in these Hill-Burton hospitals.

I would also like to clarify something here. When we speak of out of retirement, we do not mean retirement because of age. We mean really withdrawal from their profession. Many of these nurses, for various reasons, and particularly during the war, met young men who were serving their country and married these young men and returned to the homes of these young men. Many of them were from small towns where they did not have a hospital. These girls have spent years of their lives in training to render a service to mankind and were unable to do so because there was no hospital there. Then, when the hospital was built in their hometown, one of the first things that happened was that people interested in getting the hospital would go to the people identified with health—physicians, nurses, dentists, and professional people, and other people, too—and say to these ladies: "Will you help us get a hospital?" And they often became captains of the fund-drive campaign. Then, when the hospital was completed, they frequently took employment in that hospital on a full- or part-time basis.

I think you will find, sir, that that is the reason why a great number of our Hill-Burton hospitals are being operated today, and small hospitals even outside of Hill-Burton, because these ladies are serving their fellow men through these endeavors, and they would not have the opportunity to do so if the hospital were not there. As a result they are able to return to their profession.

EFFECT OF PROGRAM ON SUPPLY OF DOCTORS IN NONURBAN AREAS

Mr. BUSBEY. Starting with the last sentence of page 3 of your prepared statement, you state:

> Modern and efficient hospitals built under the Hill-Burton program have not only retained physicians in rural communities but also have attracted additional physicians. For example, a survey was made in 6 Southeastern States of the 56 Hill-Burton hospitals which had been in operation 1 year or more. It was found that 156 general medical practitioners, surgeons, and specialists had been attracted to 47 of these 56 communities.

Now, if these hospitals had been built in these same communities without Hill-Burton funds would not the same number of doctors have been attracted?

Dr. CRONIN. I would say, Mr. Chairman, if a modern hospital were put in a community, regardless of who built it, and the same facilities were included in that hospital, the physicians would be attracted to it, and the physicians in the community would be retained there, because they would have the facilities to practice their profession, utilizing the instruments of precision which the modern sciences of physics and chemistry have contributed to the medical profession.

PERCENTAGE OF OCCUPANCY OF HILL-BURTON HOSPITALS

Mr. BUSBEY. What was the percentage of occupancy of those 56 hospitals?

Dr. CRONIN. We can supply that to you for the record.

Mr. BUSBEY. If you will, please.

(The information is as follows:)

6 State survey of 56 projects in operation 1 year or longer showing percentage of occupancy

Location	Name	Size of hospital	Percent of occupancy
Alabama:			
Hamilton	Lister Hill	37	19
Langdale	George H. Lanier Memorial	87	73
Marion	Perry County	20	49
Mobile	Martin De Porres	35	84
Montgomery	St. Jude	152	45
Opp	Mizell Memorial	29	55
Ozark	Dale County	50	24
Union Springs	Bullock County	28	78
Florida:			
Chipley	Washington County	28	77
Live Oak	Suwannee County	36	70
Panama City	Bay County	58	38
Pensacola	Baptist Memorial	158	59
Tallahassee	Memorial	150	54
Do	Florida A. and M	100	48
Georgia:			
Adel	The Memorial	25	60
Baxley	Baxley, Appling County	27	52
Camilla	Mitchell County	32	54
Carrollton	Tanner Memorial	40	46
Chatsworth	Murray County Memorial	19	47
Columbus	St. Francis	154	51
Dawson	Terrell County	27	23
Elberton	Elbert County	50	100
Franklin	Heard County Memorial	18	57
Gainesville	Hall County Memorial	112	27
Greensboro	Minnie G. Boswell Memorial	28	51
Griffin	Griffin-Spalding County	101	70
Lagrange	City-County	140	65
Marietta	Kennestone	103	41
Richland	Stewart-Webster	24	50
Sylvania	Screven County General	34	34
Sylvester	Worth County	29	56
Thomaston	Upson County	100	33
Mississippi:			
Belzoni	Humphreys County Memorial	40	48
Booneville	Northeast Mississippi	50	99
Carthage	Leake County Memorial	50	25
Collins	Covington County	25	47
Columbia	Marion County General Hospital	80	45
DeKalb	Kemper County Hospital	25	41
Durant	District 2 Community	25	49
Leakesville	Greene County	25	13
Lucedale	George County	30	38
Meadville	Franklin County Memorial Hospital	30	40
Rolling Fork	Sharkey-Issaquena Community	22	29
Ruleville	North Sunflower County	31	92
Starkville	Felix Long Memorial	40	63
Tunica	Tunica County	25	47
South Carolina:			
Bishopville	Lee County Memorial	43	31
Georgetown	Georgetown County Memorial	52	77
Hampton	Hampton County	25	63
Loris	Loris Community	25	63
Manning	Clarendon County	52	54
Tennessee:			
Cookeville	Cookeville	49	45
Crossville	Cumberland Medical Center	50	47
Jackson	Jackson and Madison Counties	128	77
Pulaski	Giles County Hospital and Health Center	41	37
Union City	Obion County	60	59

Dr. CRONIN. I would like to make a statement in that regard: The percentage of occupancy of a hospital is dependent on many factors. One of the most important is the factor of whether or not the community had a hospital before. People have to learn to use the hospitals. Physicians have to learn to use a hospital. Physicians who have practiced without a hospital for many years will not use the hospital the way a physician who has graduated in comparatively recent years will use a hospital.

Also, the occupancy rate of a hospital is very much like the young child. We all have to learn to crawl, and then to learn to walk, and then to learn to run. Our hospitals are of that general character.

SHORTAGES IN HOSPITAL PERSONNEL

Mr. BUSBEY. Even if you could provide all of the beds that you have estimated as required, where would we get the nurses and other personnel to operate the hospitals?

Dr. CRONIN. Mr. Chairman, if we could provide all of the beds that this country needs—I should state that we have only 54 percent of the need met in this country, so far as beds are concerned, and we have an 850,000-bed deficit at the present time—I do not think it would be possible to find an adequate number of staff to staff all those hospitals during this year or any year because I do not think this country ever will get up to the point where we will supply all of the beds we need.

Mr. BUSBEY. I think we will all agree that at the present time there is a shortage of nurses. Is that not an accepted fact?

Dr. CRONIN. I think definitely there is a shortage of nurses. I think there is a very definite maldistribution of nurses, too.

FEDERAL ACTIVITIES TO INCREASE SUPPLY OF NURSES

Mr. BUSBEY. Appreciating that this is not your responsibility, and does not come within your jurisdiction, do you by any chance know what is being done to increase the supply of nurses in the country?

Dr. CRONIN. As you have stated, this is not my particular area of operation, although I am very much interested in it.

Mr. BUSBEY. Yes.

Dr. CRONIN. I think everything that can be done is being done within the limits of appropriations for the activity.

By that I mean that the Public Health Service, through its Nursing Resource Division, and through its Chief Nurse, is doing its best to catalyze interest in young girls to enter the field of nursing, helping them to study just what is "nursing," and what nursing is required at the so-called professional registered nurse level, at the levels below, such as nurse assistants and nurses' aide, and this all get into an area which, according to my feeling, is very great, and where there is much need, and that is the area of study concerning the utilization of professional personnel and a study of the effective utilization of hospital facilities.

Mr. Chairman, as you know, we appeared before this committee several years ago and requested money under Public Law 380 which amended Public Law 725, which permitted the Federal Government to get money to give to the communities and people to stimulate study by demonstration studies.

This committee, if I remember, looked with favor upon that request. However, upon the floor of the House, by one vote, that request was denied. I personally think it is working a severe hardship, on really the people of the country, in regard to effective utilization of nursing personnel, medical personnel, and the effective utilization of hospitals and so on. I think there is a terrific need for studies and investigations and demonstrations because it is inconceivable to me

how we can furnish $542,500,000 and be a part of a $1,500,000,000 operation in a field of building hospitals, and yet have the very minimum of research going on concerning these hospitals, and the hospital picture in general.

I feel very strongly on this subject, and feel that we should have research going on in this area of utilization of personnel in hospitals, of utilization of hospitals and beds; that we should have research on the development of guidelines and techniques in the whole area of the operation and administration of hospitals.

Not that I would advocate for a minute that the Federal Government should operate the hospitals. I do not think they should, but I do think the Federal Government has a responsibility to assist the people who are operating these hospitals by helping them to study, and by demonstrations, to show better and more effective utilization.

NURSE TRAINING WORK OF OFFICE OF EDUCATION

Mr. BUSBEY. The other evening when I was thinking of this shortage of nurses, and of some of the testimony and the facts that this committee has uncovered in regard to programs in the field of vocational education, particularly in distributive education, I wondered if it would not be a great deal better to include some kind of a nurses' training program within the vocational education program, in preference to some of the programs that are being carried on within it now. If young girls were made interested and were exposed to the elements of nurses' training in their high-school work there might be a good chance that many of them would continue their interest by training to be nurses. They certainly would go into the field much better equipped and with a better basic knowledge of what is required of a nurse. Perhaps as a result of such a program many nursing trainees would not be leaving the profession after they have started their training, as they are doing at the present time.

Dr. SCHEELE. I was just going to sit here and listen, but on this one subject I may be able to shed a small amount of light.

Mr. BUSBEY. We are always very happy to have you participate in the discusions.

Dr. SCHEELE. The Office of Education does conduct, or assists in conducting, a program in vocational education, and one very small part of that is the stimulation of practical-nurse training. This is done at the high-school level, and the Public Health Service provides a very small amount of assistance to them in the form of a consultant nurse who is an expert in the field at the present time.

Through the little effort made there, a great deal of important effort is being made in the high schools to interest girls, in this case not so much in becoming registered nurses, but in the area of practical nursing, and I think that as a natural byproduct many of the girls will go on and become registered nurses later.

The original start of interest is being created through some action in the vocational-education program. I cannot speak of the details. I think we know some of the things to do. Our big problem is that there needs to be a more intensive program by the voluntary nursing groups, citizens in the communities and elsewhere, focused on this whole problem of getting girls interested in nursing.

AVERAGE OCCUPANCY AND SIZE OF HOSPITAL

Mr. BUSBEY. I am not ready to advocate a program of nursing training in vocational education, but, as I previously said, this might be a much more practical application of some of the funds that are allocated to vocational education than some of the programs that are being carried on at present.

Now, Dr. Cronin, has not the Commission on Hospital Care prepared a table on hospital occupancy ratios?

Dr. CRONIN. They have. They did it as a part of the hospital-care study.

Mr. BUSBEY. Do you have that table?

Dr. CRONIN. Yes; we have.

Mr. BUSBEY. Without objection, it will be inserted in the record at this point.

(The information requested is as follows:)

RELATIONSHIP OF BED OCCUPANCY TO SIZE OF FACILITY

(Data based on findings by the Commission of Hospital Care)

Average occupancy and size of hospital.—Studies have shown that the average occupancy varies in proportion to the size of the hospital; the larger the hospital the greater the average occupancy. If average occupancy of existing hospitals is high in an area, that area would have greater justification for additional beds from the pool than another area with the same bed ratio having a lower average occupancy. The following table indicates the expected percentage of occupancy of hospitals:

Size of hospital—number of beds	Expected percentage occupancy		Size of hospital—number of beds	Expected percentage occupancy	
	Low	High		Low	High
10	30	40	75	63	71
20	42	52	100	67	74
30	49	58	150	72	78
40	54	62	200	75	81
50	57	66	300	79	84
60	60	68	500	83	87

Mr. BUSBEY. How many of the Hill-Burton facilities are below the low-occupancy ratio?

Dr. CRONIN. We have not had the staff, nor facilities within our appropriation and personnel restrictions to make that study. We will be more than pleased to make such a study if we have such money and facilities. We can furnish for the record information that we have on it, if you so desire. We have only an eight-State report, which is a part of a request we have from the investigating body.

DATA RELATING TO HILL-BURTON PROJECTS IN SELECTED STATES

Mr. BUSBEY. I do not want to burden the office with additional work for which you have not had money appropriated, but as long as you have the study for the eight States, I wonder if out of that study you could compile a table showing each facility by States, its size, the date the facility was opened, the date of report, the percent-

age of occupancy, the Federal funds that have been allotted to each facility, and the total cost of each.

Dr. CRONIN. Mr. Chairman, in order to keep me straight on exactly what we are going to do here, I would like to point out that many of the Hill-Burton projects are equipment only projects; in other words, we help only in the equipping of a hospital. That hospital might have been in existence for 50 years. It might have been built without Hill-Burton funds whatsoever. What is your idea, sir?

Mr. BUSBEY. That will show as equipping of a hospital.

Dr. CRONIN. You would like those projects identified?

Mr. BUSBEY. Yes. I do not believe that should prove too difficult.

Dr. CRONIN. Also for clarification, some of our projects are additions to a hospital that is in existence, and to get the occupancy rate upon those particular hospitals we are going to have to inquire of the State agencies, and I would like also to indicate in many instances our source of information on occupancy rates is going to be the tables published by the American Hospital Association and by the American Medical Association, which may not be exactly current.

Mr. BUSBEY. Very well then, leave out the additions, and only show the new projects.

Dr. CRONIN. Yes.

(The tables referred to follow:)

Location	Name	Category	Type construction	Beds added	Beds upon completion	Date opened	Percent occupied	Source of information*	Total cost	Federal share
Ashland	Clay County	General	New	20	20	September 1952.	52	SP	$270,102	$175,034
Athens	Athens Limestone Co	do	do	50	50	May 1951	28	RO	672,134	439,241
Birmingham [1]	Carraway Methodist	do	Addition		240	April 1950	64	SP	554,443	184,815
Do	365 Crippled Children's Clinic	do	New	100	100	July 1951	76	SP	1,876,969	566,018
Do	St. Vincents	do	Addition	99	213	November 1950.	67	SP	1,559,473	483,206
Decatur	District 1 TB Sanitorium	TB	New	161	161	December 1951.	97	SP	1,144,693	754,984
Fort Payne	De Kalb County General	General	do	55	55	April 1952	31	SP	606,235	400,554
Hamilton	Lister Hill	do	do	37	37	December 1951.	19	RO	451,645	286,363
Langdale	George H. Lanier Memorial	do	do	87	87	August 1950	73	RO	2,106,398	719,009
Marion	Perry County	do	do	20	20	January 1951	49	RO	225,386	73,438
Mobile	Martin De Porres	do	do	35	35	May 1950	84	RO	611,425	195,475
Do	Mobile Infirmary	do	do	300	300	January 1952		NI	4,368,580	2,781,509
Do	Providence	do	do	200	200	August 1952		NI	3,551,404	2,000,000
Do	Psychiatric Receiving and Diagnostic Unit.	Mental	Addition	20	320	May 1951		NI	138,001	45,000
Montgomery	St. Jude	General	New	152	152	June 1951	45	RO	1,345,067	438,663
Opelika	Lee County Hospital and Health Center.	General and public health clinic.	do	80	80	February 1952		NI	1,040,211	653,340
Opp	Mizell Memorial	General	do	29	29	December 1949	55	RO	470,998	153,666
Ozark	Dale County	do	do	50	50	August 1951	24	RO	572,672	381,029
Tuscaloosa	Bryce	Mental	Addition	125	2,058	July 1950		NI	346,408	230,137
Tuskegee	Macon County	General	New	[2]	30	do		NI	160,670	23,780
Union Springs	Bullock County	do	do	28	28	July 1951	78	RO	320,804	206,143
Vernon	Lamar County	do	do	30	30	November 1952.		NI	455,702	298,802

*RO—Indicates latest information on file in regional office Mar. 11, 1953, represents figures at end of calendar year 1952.
NI—No information available.
SP—State plan dated July 1952.

[1] Nurses' residence 100 nurses beds.
[2] Equipment only.

CALIFORNIA

Location	Name	Category	Type construction	Beds added	Beds upon completion	Date opened	Percent occupied	Source of information*	Total cost	Federal share
Alturas	Modoc General	General	New	39	39	April 1951	49	SP	$841,000	$275,000
Banning	San Gorgonia Pass Memorial	do	do	37	37	March 1951	30	SP	591,501	183,300
Bishop	Northern Inyo	do	do	30	30	November 1949.	48	SA	473,230	155,327
Brawley	Pioneers Memorial	do	do	100	100	October 1950	50	SA	1,566,019	491,598
Corcoran	Corcoran Municipal	do	do	(1)	(1)	January 1949	44	SA	48,004	16,001
Dinuba	Alta	General and public health clinic.	do	50	50	February 1951	50	SA	812,516	266,805
Escondido	Palomar Memorial	General	do	37	37	February 1950	83	SA	466,328	155,442
Gridley	Biggs Gridley Memorial	do	do	(2)	(2)	June 1949	83	SA	370,385	16,248
Hemet	Hemet Valley	do	Addition and remodeling.	10	35	April 1949	70	SA	265,543	88,514
Inglewood	Gentinela Valley Community	do	Addition and replacement.	39	98	September 1952.	-------	NI	200,546	63,938
Loyalton	Sierra Valley	do	New	10	10	July 1951	40	SA	180,415	59,722
Mariposa	John C. Fremont	do	do	20	20	October 1951	75	SA	418,717	126,433
Merced	County	do	Addition	88	88	February 1952	77	SP	1,131,782	371,060
Modesto	Memorial Stanislaus County	do	New	92	92	September 1951.	64	SA	1,211,575	400,000
Do	Stanislaus County Central Unit	do	Addition	17	177	September 1952.	-------	NI	1,465,575	323,772
Needles	Municipal	do	Addition and remodeling.	10	20	December 1949.	39	SA	277,910	89,672
Paso Robles [3]	Paso Robles War Memorial	do	New	24	24	August 1950	40	SA	598,051	199,350
Patterson	Patterson Hospital District	do	do	25	25	November 1952.	-------	NI	445,254	145,160
Roseville [4]	Roseville Municipal	do	do	(2)	26	October 1951	57	SA	277,950	17,000
San Andreas	Mark Twain	do	do	30	30	May 1952	-------	NI	627,507	209,169
San Rafael	Marin District	do	do	108	108	December 1948.	50	SA	1,825,702	576,920
Tracy	Tracy Community Memorial	do	do	42	42	April 1952	-------	NI	227,979	73,583
Truckee	Tahoe Forest District	do	do	21	21	February 1951	43	SA	403,238	127,747
Tulare	Tulare District	do	do	73	73	March 1951	62	SP	1,299,500	416,500
Ventura	Foster Memorial	do	Addition and remodeling.	20	80	July 1950	84	SA	415,805	138,602
Weaverville	Trinity County	do	New	20	20	November 1950.	53	SA	352,215	117,405
Willows	Glenn County	do	do	42	42				633,824	211,275

[1] Laboratory.
[2] Equipment only.
[3] Pickup.
[4] Pickup, equipment only, fraction.

*SA—Indicates latest information on file with State agency Mar. 12, 1953 and usually represents 12-month period ending Dec. 31, 1952.
NI—No information available.
SP—State plan dated July 1952.

Location	Name	Category	Type construction	Beds added	Beds upon completion	Date opened	Percent occupied	Source of information*	Total cost	Federal share
Adel [1]	The Memorial	General	New	25	25	August 1950	60	RO	$193,800	$116,280
Arlington	Arlington City	do	do	16	16	April 1951	8	RO	158,900	95,340
Athens	Athens General	do	Addition	22	106	do	69	SP	522,900	184,300
Atlanta	Grady Memorial, Negro	do	do	116	116	July 1952		NI	1,725,984	1,035,590
Baxley	Baxley Appling County	do	New	27	27	June 1951	52	RO	257,196	154,318
Camilla	Mitchell County	do	do	32	32	September 1949	54	RO	268,139	89,380
Carrollton	Tanner Memorial	do	do	40	40	November 1949	46	RO	528,000	176,000
Cedartown	Polk General	do	Addition and remodeling	10	40	July 1951	85	SP	69,500	41,700
Chatsworth	Murray County Memorial	do	New	[3]	19	January 1950	47	SP	41,000	13,667
Clayton	Rabun County	do	do	20	20	November 1951	29	SP	237,000	130,350
Columbus	St. Francis	do	do	154	154	April 1950	51	RO	1,909,807	636,602
Dawson	Terrell County	do	do	27	27	April 1951	23	RO	255,868	153,520
Demorest	Habersham County	do	do	44	44	July 1952		NI	555,200	302,625
Dublin	Laurens County	do	do	60	60	September 1952		NI	886,068	487,337
Elberton	Elbert County	do	do	50	50	September 1950	100	RO	780,276	260,092
Franklin [2]	Heard County Memorial	do	do		18	May 1949	57	SP	17,217	5,739
Gainesville	Hall County Memorial	do	do	112	112	September 1951	27	RO	1,666,228	536,102
Greensboro	Minnie G. Boswell Memorial	do	do	28	28	August 1949	51	RO	401,250	133,750
Griffin	Griffin-Spalding County	do	do	101	101	January 1951	70	SP	1,321,491	440,497
Hiawassee [1]	Lee M. Happ, Jr., Memorial	do	do	12	12	February 1952		NI	179,604	98,782
Lagrange	City-County	do	Addition	74	140	September 1949	65	SP	504,000	168,000
Macon	Macon City	do	do	24	324	August 1948	98	SP	57,834	19,278
Marietta [1]	Kennestone	do	New	103	103	June 1950	41	RO	1,208,564	402,855
McRae	Telfair County	do	do	30	30	March 1952		NI	360,000	198,000
Monticello	Jasper County	do	do	25	25	January 1952		NI	260,000	143,000
Richland	Stewart-Webster	do	do	24	24	March 1949	50	RO	255,536	85,179
Rome	Battey State	TB	Remodeling	[4]		March 1952	82	SP	153,413	84,377
Royston	Cobb Memorial	General	New	20	20	January 1950	54	RO	213,460	71,153
Summerville	Chattooga County	do	do	31	31	January 1952		NI	345,000	189,750
Swainsboro	Emanuel County	do	do	50	50	June 1952		NI	591,790	355,074
Sylvania	Screven County General	do	do	34	34	September 1951	34	RO	332,000	199,200
Sylvester	Worth County	do	do	29	29	February 1950	56	RO	293,114	97,705
Thomaston	Upson County	do	do	100	100	April 1951	33	RO	1,122,000	374,000
Thomson	McDuffie County	do	do	29	29	January 1952		NI	325,500	195,300
Toccoa	Stephens County	do	Addition and remodeling	5	44	July 1952		NI	424,000	254,400
Waynesboro	Waynesboro-Burke County	do	New	33	33	May 1951	30	RO	416,070	249,642
Winder	Barrow County	do	do	40	40	December 1951		NI	550,000	302,500

[1] Pickup.
[2] Equipment.
[3] Pickup, equipment only, and fraction.
[4] Laboratory.

*RO—Indicates latest information on file in regional office Mar. 11, 1953, represents figures at end of calendar year 1952.
SP—State plan dated July 1952.
NI—No information available.

ILLINOIS

Location	Name	Category	Type construction	Beds added	Beds upon completion	Date opened	Percent occupied	Source of information*	Total cost	Federal share
Aledo	Mercer County	General	New	50	50	December 1950	51	SA	$801,233	$267,078
Anna	Anna City	do	do	50	50	March 1951	58	SA	1,161,976	387,325
Cairo	St. Marys Nurses Home	do	Addition		95	October 1949	72	SP	402,754	134,251
Carlinville	Carlinville General	do	New	53	53	July 1952	46	SA	912,000	353,856
Carthage	Hancock County	do	do	50	50	October 1950	61	SA	741,475	247,159
Chicago	Provident Hospital Training School	do	Addition and remodeling	30	210	August 1951	63	SP	527,000	204,476
Do	Illinois Masonic	do	Addition	70	470	June 1951	61	SP	1,008,302	160,428
Evanston	Community	do	Replacement	50	50	October 1952		NI	940,000	364,720
Fairfield	Fairfield Memorial	do	New	100	100	July 1950	82	SA	1,242,983	414,328
Flora	Clay County	do	do	50	50	March 1950	42	SA	906,295	302,099
Gibson	Gibson Community	do	do	40	40	October 1952		NI	800,000	310,400
Lawrenceville	Lawrence County	General and public health clinic	do	50	50	July 1950	49	SA	971,100	323,700
Mount Carmel	Wabash County	General	do	52	52	June 1951	60	SA	904,963	301,654
Mount Vernon	Good Samaritan	do	do	100	100	May 1952	62	SA	2,199,000	733,000
Do	State TB Sanatorium	TB	do	100	100	May 1951	43	SP	2,117,267	446,693
Peoria [1]	St. Francis Forest Park	General	Addition		591	August 1950	84	SP	1,166,524	71,401
Red Bud [2]	St. Clements	do	do	64	64	October 1949	79	SA	1,096,339	238,576

*SA—Indicates latest information on file with State agency Mar. 11, 1953, and represents the 6-month period ending Dec. 31, 1952.
SP—State plan dated July 1952.
NI—No information available.

[1] Pickup, equipment only, and fraction.
[2] Pickup.

Location	Name	Category	Type construction	Beds added	Beds upon completion	Date opened	Percent occupied	Source of information*	Total cost	Federal share
Anoka	Anoka State	Mental	Addition	60	832	March 1952	123	SP	$1,233,312	$553,190
Appleton	Appleton Municipal	General	Replacement	20	20	July 1952		NI	429,606	185,403
Bagley	Clearwater County Memorial	do	New	30	30	August 1950	87	SA	331,160	110,387
Baudette	Baudette Municipal	do	do	24	24	March 1950	72	SA	333,279	110,225
Benson	Swift County-Benson	do	do	(1)	40	June 1950	59	SA	371,611	37,973
Blue Earth	Community Memorial	do	do	32	32	September 1950	48	SA	454,695	151,565
Breckenridge	St. Francis and Nurses Home	do	do	123	123	September 1952		NI	2,162,143	971,254
Buffalo	Buffalo Memorial	do	do	28	28	September 1951	63	SA	358,696	160,518
Crookston [2]	St. Francis	do	do		140	June 1950	60	SA	1,865,793	79,282
Duluth [3]	St. Lukes Hospital	do	Addition and remodeling		355	December 1951	103	SP	2,435,000	15,750
Do	St. Lukes Infirmary	Chronic	New	150	473	November 1951	96	SA	1,161,961	387,320
Greenbush [3]	Greenbush Community	General	do	20	20	February 1950	65	SA	250,585	74,948
Litchfield	Meeker County	do	do	62	62	June 1952	50	SA	870,290	391,630
Minneapolis	Variety Club Heart	Chronic	do	78	78	March 1951		NI	1,400,507	381,672
Morris	Stevens County Memorial	General	do	40	40	February 1951	50	SA	544,650	245,092
New Prague	Community Memorial	do	do	32	32	February 1952	56	SA	429,472	193,262
Olivia	The Renville County	do	do	41	41	February 1951	61	SA	399,920	133,306
Ortonville	Ortonville Municipal	do	do	30	30	April 1952		NI	377,335	169,801
Pelican Rapids	Pelican Valley Health Center	do	do	23	23	August 1951	52	SA	263,730	118,679
Red Lake Falls	St. Johns	do	do	20	20	October 1951	56	SA	416,023	186,337
Redwood Falls	Redwood Falls	do	Replacement	40	40	November 1952		NI	537,446	241,851
Sauk Centre	St. Michaels	do	New	50	50	September 1950	73	SA	760,971	253,657
Slayton	Murray County Memorial	do	do	40	40	February 1951	38	SP	469,347	150,745
Wells	Village of Wells Hospital	do	do	32	32	October 1950	35	SA	331,751	110,583
Wheaton	Wheaton Community	do	do	22	22	December 1950	44	SA	251,008	83,429
Worthington	Worthington Municipal	do	do	50	76	May 1951	50	SA	682,922	227,141
Do	do	do	Addition	27	76	do		SA	314,004	140,972

*SA—indicates latest information on file with State agency, Mar. 12, 1953, and usually represents 12-month period ending Dec. 31, 1952.
SP—State plan dated July 1952.
NI—No information available.

[1] Equipment.
[2] Pickup, equipment only, fraction.
[3] Pickup.

MISSISSIPPI

Location	Name	Category	Type construction	Beds added	Beds upon completion	Date opened	Percent occupied	Source of information [1]	Total cost	Federal share
Ripley	Tippah County Hospital	General	New	40	40	April 1950	62	SA [1]	$448,307	$145,229
Ashland	Ashland Clinic	General and public health clinic.	do	6	6	September 1951		NI	122,456	80,874
Belzoni	Humphreys County Memorial	General	do	40	40	January 1951	48	SA [1]	335,000	108,250
Booneville	Northeast Mississippi	do	do	50	50	December 1949	99	SA [1]	600,973	195,638
Canton	Kings Daughters	do	Remodeling	29	69	May 1952	45	SA	422,465	281,510
Carthage	Leake County Memorial	do	New	50	50	September 1951	25	SA	528,520	166,640
Centreville	Field Memorial	do	do	50	50	March 1952	61	SA	507,201	331,334
Clarksdale	Coahoma County Hospital	do	do	100	100	November 1952		NI	1,301,094	809,870
Collins	Covington County	do	do	25	25	July 1951	47	SA	220,882	144,338
Columbia	Marion County General Hospital	do	do	80	80	October 1950	45	SA [1]	847,974	280,751
DeKalb	Kemper County Hospital	do	do	25	25	September 1950	41	SA	228,611	74,695
Durant	District 2 Community	do	do	25	25	December 1950	49	SA [1]	253,924	82,878
Ellisville	Ellisville Municipal Clinic	General and public health clinic.	do	8	8	August 1950	83	SA	81,884	26,747
Forest	Southeastern Lackey Memorial	General	do	47	47	September 1951	30	SA [1]	414,890	132,896
Gloster	Gloster Clinic	General and public health clinic.	do	4	4			NI	50,029	14,843
Greenwood	Greenwood Leflore	General	Replacement	135	135	April 1952	72	SA	1,771,340	1,157,560
Hattiesburg	Forrest County	do	New	100	100	July 1952	50	SA [1]	1,303,781	859,954
Hazelhurst	Hardy Wilson Memorial	do	do	50	50	September 1950	53	SA [1]	692,941	227,585
Laurel	Jones County	do	do	105	105	February 1952	39	SA [1]	1,188,725	775,817
Leakesville	Greene County	do	do	25	25	October 1950	13	SA	235,619	77,990
Lexington	Holmes County Community	do	Addition	16	41	February 1952	37	SA	216,487	144,228
Lucedale	George County	do	New	30	30	September 1950.	38	SA	272,217	88,105
Macon	Noxubee County Community	do	do	40	40	March 1952	43	SA	622,943	406,962
Meadville	Franklin County Memorial Hospital	do	do	30	30	February 1951	40	SA	269,537	87,790
Meridian	East Mississippi Mental	Mental	do	260	260	March 1952	92	SA	1,588,152	1,058,768
Okolona	Okolona	General	do	25	25	November 1952.	11	SA	246,540	161,927
Port Gibson	Claiborne County	do	do	25	25	January 1952	31	SA [1]	245,000	160,500
Prentiss	Jefferson Davis County	do	do	26	26	November 1950.	93	SA [1]	223,730	72,843
Rolling Fork	Sharkey Issaquena Community	do	do	22	22	February 1951	29	SA	192,111	62,120
Ruleville	North Sunflower County	do	do	31	31	October 1950	92	SA [1]	417,287	137,929
Sanatorium	TB Infirmary for Negroes	TB	Addition and remodeling.	154	619	April 1952	65	SA	1,753,115	584,372

Starkville	Felix Long Memorial	General	New	40	40	December 1950.	63	SA[1]	415,106	128,463
Tunica	Tunica County	do	do	25	25	November 1950.	47	SA[1]	228,027	73,406
Tupelo	North Mississippi Community	do	Addition and remodeling.	48	94	January 1951	80	SA	297,674	197,522
Waynesboro	Wayne County	do	New	25	25	April 1951	40	SA	213,618	139,506
Wiggins	Stone County	do	do	20	20	July 1951	27	SA[1]	174,623	112,615

[1] Latest information from State agency Mar. 13, 1953, for month ending Jan. 31, 1953.
NI—No information available.

SA—Indicates latest information from State agency Mar. 13, 1953, usually for 12-month period ending Sept. 30, 1952.

Location	Name	Category	Type construction	Beds added	Beds upon completion	Date opened	Percent occupied	Source of information*	Total cost	Federal share
Aiken	Aiken County	General	Addition	50	113	October 1950	60	SP	$482,676	$150,626
Bamberg	Bamberg County Memorial	do	New	32	32	September 1952.		NI	514,108	334,170
Bishopville	Lee County General	do	do	43	43	February 1952		NI	537,424	295,583
Chester	Chester County	do	do	74	74	July 1952		NI	941,368	468,827
Columbia [1]	Good Samaritan Waverly	do	do	42	42	September 1952.		NI	229,649	134,302
Do	South Carolina State Hospital	Mental	Remodeling						60,840	20,280
Do	do	do	Addition						72,023	24,008
Do	do	do	New	(2)	1,673	June 1952		NI	215,870	71,957
Do	do	do	Addition						132,457	79,475
Fairfax	South Carolina State	do	do	50	1,709	do		NI	174,299	104,580
Florence	Allendale County	General	New	(2)	27	April 1950	44	SP	58,984	32,441
Georgetown	Flor Darlington TB Sanatorium	TB	do	118	118	August 1952		NI	854,508	448,617
Do	Georgetown County Memorial	General	do	52	52	March 1950	77	RO	529,954	173,864
Greenville	do	do	do	(4)	50				60,472	33,259
Greer	Greenville General	do	Addition	(2)	547	August 1950	87	SP	342,698	171,350
Hampton	Allen Bennett Memorial	do	do	28	28	May 1952		NI	501,860	175,000
	Hampton County	do	New	25	25	November 1950.	63	RO	292,124	91,541
Loris	Loris Community	do	do	25	25	April 1950	63	RO	165,496	55,165
Manning	Clarendon County	do	do	52	52	April 1951	54	RO	582,129	191,773
Newberry	Newberry County	do	Addition and remodeling.	38	64	February 1951	45	SP	360,032	120,010
Rock Hill	York County	do	Addition	62	141	December 1949.	12	SP	541,103	180,368
Seneca	Oconee memorial	do	do	40	75	March 1950	64	SP	151,078	50,359
Spartanburg	Spartanburg	do	Addition and remodeling.	64	370	March 1951	83	SP	1,374,650	458,217
Do	Spartanburg General	do	do	(2)					124,941	62,470
State Park	South Carolina Sanatorium	TB	do	(2)	964	March 1951	88	SP	469,788	156,596
Do	South Carolina State Sanatorium	TB	Addition	207		June 1951			105,504	52,751
Do	do	TB	Addition and remodeling.	(2)		do			28,575	14,287
Do	do	TB	Addition	(2)		December 1951.			26,026	13,013

Do	South Carolina State Hospital	Mental	New	(1)	1,621				17,585	5,862
Do	do	do	Addition and remodeling.	(2)					63,080	21,027
Do	do	do	Addition	240	1,781	February 1949		NI	487,284	162,429
Do	do	do	New	(1)					107,991	35,997
Do	do	do	Addition	(2)	1,845				130,027	78,017
Do	South Carolina State	General	Addition and remodeling.	60	60	October 1950	25	SP	733,715	244,572
Union	Union County	do	New	101	101	July 1952		NI	1,077,628	609,705
Walterboro	Colleton County									

*RO—Indicates latest information on file in regional office Mar. 11, 1953, represents figures at end of calendar year 1952.
SP—State plan dated July 1952.
NI—No information available.

[1] Pickup.
[2] Service facilities.
[3] Equipment only.
[4] Nurses' home.

TENNESSEE

Location	Name	Category	Type construction	Beds added	Beds upon completion	Date opened	Percent occupied	Source of information*	Total cost	Federal share
Chattanooga	Chattanooga TB	TB	New	120	120	October 1951	13	SP	$2,098,360	$699,453
Cookeville	Cookeville	General	do	49	49	December 1950.	45	RO	600,142	189,047
Crossville	Cumberland Medical Center	do	do	50	50	March 1950	47	RO	707,860	235,787
Fayetteville	Lincoln County	do	Addition	35	77	June 1950	47	SP	497,409	164,750
Jackson	Jackson and Madison Counties	General and public health clinic.	New	128	128	August 1950	77	RO	1,839,628	589,880
Johnson City	Johnson City Memorial	General	Addition	84	152	February 1951	55	SP	1,245,265	408,488
Do	do	do	do	36	178				113,736	59,143
Kingsport	Holston Valley Community	do	do	126	240	May 1952		NI	2,100,852	817,002
Knoxville	Eastern State	Mental	do	188	1,538	January 1951	99	SP	1,579,339	421,446
Do	East Tennessee Crippled Children's	Chronic	Addition and remodeling.	40	62	June 1951	35	SP	523,864	267,332
Do	East Tennessee TB	TB	Replacement	180	180	January 1951	74	SP	3,249,422	1,089,229
Lawrenceburg	Lawrence County	General and public health clinic.	New	50	50	August 1951	40	SP	527,548	172,349
Maryville	Blount	General	Addition and remodeling.	62	112	January 1950	83	SP	576,921	192,307
Memphis [1]	West Tennessee TB	TB	New		400	May 1949	96	SP	285,048	95,016
Do	LeBonheur Children's	Chronic	do	100	100	June 1952		NI	2,195,761	1,104,721
Murfreesboro	Rutherford	General	Addition and remodeling.	32	73	July 1952		NI	508,439	235,600
Nashville	Central State	Mental	Addition	[2]	2,180	July 1950	94	SP	70,000	36,400
Pulaski	Giles County Hospital and Health Center.	General and public health clinic.	New	41	41	November 1950.	37	RO	414,778	131,826
Ripley	Lauderdale County	General	do	55	55	do	45	SP	531,746	172,249
Savannah	Hardin County	General and public health clinic.	do	50	50	December 1950.		NI	797,258	405,158
Sewanee	Emarald Hodgson	General	Remodeling	NH	46	April 1952	47	SP	150,446	78,332
Shelbyville	Bedford County	General and public health clinic.	New	58	58	April 1951		NI	863,905	438,831
Union City	Obion County	General	do	60	60	October 1950	59	RO	760,158	251,310

*RO—Indicates latest information on file in regional office Mar. 11, 1953, represents figures at end of calendar year 1952.
SP—State plan dated July 1952.

NI—No information available.

[1] Pickup, equipment only, and fraction.
[2] Equipment

Mr. BUSBEY. What is the total number of surplus beds in the Hill-Burton financed facilities?

Dr. CRONIN. I do not quite understand your question?

Mr. BUSBEY. You have a figure of percentage occupancy, and you would have also the total number of beds. The difference between the figures should represent the number of surplus beds.

Dr. CRONIN. Mr. Chairman, according to the standard practices and standard understandings about bed occupancy of a hospital, and utilizing the bed occupancy expected, high and low, as shown by the Commission on Hospital Care studies, the surplus beds you refer to would be those beds that were built into that hospital as a hospital in excess of the highest expected occupancy of that hospital.

For instance, according to the Commission on Hospital Care's expected percentage occupancy for a 50-bed hospital, I would like to point out that in a 50-bed hospital in Seattle, Wash., it is entirely different from a 50-bed hospital in Paducah, Ky., or Orangeburg, S. C., and at any one time the occupancy is going to vary so greatly with seasonal variations, epidemics, and so on, but the national expected average on a 50-bed hospital runs from 57 to 66 percent, so the 50-bed hospital 66 percent full would have approximately thirty-some-odd beds occupied.

Mr. BUSBEY. The table you are going to supply ought to have the low occupancy and the high occupancy to be comparable to the Commission's table. Also show the percentage of occupancy as of December 1952.

Dr. CRONIN. We will attempt to get it for that date, but very frequently occupancy rates on hospitals are confidential matters as far as the hospital staff administrators are concerned, and are not released, particularly if it is a Government hospital, until they bring up their budget requests before their own State legislatures. We will do our best to get the occupancy rates, but I cannot guarantee you we can give you the December 1952 rate.

Mr. BUSBEY. Whatever you get will be satisfactory.

FEDERALLY FINANCED HOSPITALS WHICH HAVE BEEN CLOSED

Mr. BUSBEY. Have there been any hospitals financed under the Hill-Burton program that had to close after they were opened?

Dr. CRONIN. We have three hospitals, Mr. Chairman. I would like to speak to them for a minute.

Mr. BUSBEY. Will you tell the committee about those, please?

Dr. CRONIN. The Halifax County Community Clinic, Scotland Neck, N. C., a 20-bed facility, constructed at a total cost of $161,484, with the Federal funds amounting to $53,333, opened March 15, 1950. The community clinic closed April 1, 1951. At the time the community clinic opened there were three physicians. One of the physicians died, another moved away, and the one physician left was unable to keep things going.

We understand that the people in the community are vitally interested in reopening the community clinic. Also, the North Carolina Medical Care Commission and the North Carolina Medical Society are rendering assistance to the community in securing a physician and surgeon to practice there.

Our Washington, D. C., regional office is checking the situation periodically.

St. Luke's Hospital, Kearney, Nebr., project was approved for Federal participation in equipment only. The total cost of the equipment was $32,801, with the Federal participation amounting to $17,470. The hospital opened July 10, 1950, and closed in the fall of 1951, we think in September.

The main reason for the closing of the hospital appears to be that it was not being utilized by the doctors. The building is being disposed of and arrangements are being made to sell the equipment.

Our Kansas City regional office is following the proceedings and we are exercising the right of recovery as provided in section 625 (e) of the act. This is the first time this type of action has been necessary.

Hancock County Hospital and Health Center, Sneedville, Tenn., is a county health center and hospital combined in one building. The hospital portion has 11 inpatient beds. The total cost of the project was $242,083, with the Federal share amounting to $125,883.

According to the plan of operation, the county health officer is to operate both the health center and the hospital. The health center portion of the facility was opened November 1, 1951. The hospital portion is not being utilized at present. The State of Tennessee is attempting to remedy this situation. The reason given is that they have been unable to find a county health officer who would and could run the health department and the hospital.

The Atlanta regional office is checking the situation periodically and at the present time we understand that the county officials are making every effort to secure a qualified official so that they can start operating the hospital portion of the building.

Mr. Chairman, those are the 3 projects out of the 2,000 approved, and over 1,100 which are completed and in operation—there are only these 3 that are not in operation.

COOPERATION BETWEEN FEDERAL, STATE, AND LOCAL SERVICES

Mr. BUSBEY. Thank you.

The last sentence of the first paragraph on page 4 of your prepared statement reads as follows:

> Other cooperative relationships in the area of administration, purchasing, pharmacy, dietetics, and graduate training, among others, will increase as time passes and recognition of the needs become apparent.

Does that sentence refer in any way to the so-called Food Center at Indianapolis that is being constructed with Hill-Burton funds?

Dr. CRONIN. It could, but in writing that sentence I had in mind that we have a great number of hospitals in this country. The Hill-Burton program is constructing about one-third of the total hospitals, being constructed in the country at the present time. All through the Hill-Burton Act the basic philosophy of cooperation is written in. That cooperation extends from the building and services rendered to a community by the small hospitals in the small towns up to the district hospitals and the services they render to their communities and to the small hospital; and to the university medical center, or base hospital, and the services that they would render to their community and to the district hospital and to the small-town hospital.

There has been developed in recent years throughout the country a great number of so-called coordinated hospital programs. In fact, the District of Columbia is developing at the present time a coordinated hospital program through the new medical center that they hope to erect. The coordinated program centering around the University of Rochester is a program where assistance is given to the smaller hospitals in administrative services; in group purchasing of supplies; so they can save money, of an operational type; in diagnostic facilities and educational activities, helping the staffs of these small hospitals to keep current; and in carrying on refresher courses at the university medical centers. Similar programs are going on through the Bingham Associates plan out of Tufts College in Boston, where they have what one might describe as circuit-riding pathologists and circuit-riding X-ray men visiting small hospitals in the New England area on a certain day of the month to be available for those professional services that those small hospitals in small communities cannot be expected to give to the people, and yet the people require these services. That is what we mean in reference to cooperative relationships.

FOOD SERVICE CENTER AT INDIANAPOLIS

Mr. BUSBEY. What is this so-called food service center doing in connection with the University of Indiana? What is the object of the center?

Dr. CRONIN. The food service building at the University of Indiana is a building from which will come the basic preparation and cooking of foods for about five hospitals on that university campus which is located on the periphery of Indianapolis, Ind., at the University of Indiana. That type of operation is not an uncommon one in hospital activities, or big university activities in the country. The food service building in Indiana is a building in which will be housed the basic cooking; for instance, the preparation of salmon croquettes will be done in the food service building, and then the salmon croquettes will be put on trays and transported to the Carter Hospital, or the James Whitcomb Riley Hospital, to their kitchens, and it will not be necessary that the kitchens of those hospitals in this large medical center have the facilities for making salmon croquettes. Such activities as preparing the potatoes will be done on a bulk basis, and the potato pots filled and sent as the requisitions from these other hospitals require.

It is a form of food service, a form of food preparation which is acceptable and which is carried on in a number of places. That is the food-service program in the University of Indiana.

Mr. BUSBEY. Are there any other hospitals or facilities that will participate in this food-service program in addition to the University of Indiana?

Dr. CRONIN. About five hospitals will participate in it.

Mr. BUSBEY. Was that the original plan submitted for the building?

Dr. CRONIN. Yes.

COST OF BUILDING

Mr. BUSBEY. What is that building going to cost?

Dr. CRONIN. The estimate that we have is that the building totally would cost $4,202,054. The approved Federal share would be $1,452,235.

AREA OF BUILDING

Mr. BUSBEY. What percentage of the square-foot area of this building will be used for food preparation?

Dr. CRONIN. I would have to furnish that for the record because I do not have it at my fingertips.

Mr. BUSBEY. I may ask some more technical questions, so if you do not know, please put them in the record.

Dr. CRONIN. All right.

Mr. BUSBEY. Do you happen to know the total square feet in that building?

Dr. CRONIN. We will have to furnish that information.

Mr. BUSBEY. Will you furnish the number of square feet being used for food preparation in the building and the square feet used in the cafeteria, the gift shop, the lounge, the lobby and other nonhospital facilities, excluding, of course, the corridors?

Dr. CRONIN. Mr. Chairman, I might venture to state that a gift shop is not classified as a nonhospital facility. We feel that a conventional hospital today will have a gift shop, and it will be as much a part of that hospital as the other parts of the hospital that one normally has in the past associated with a hospital.

Many hospitals throughout the country have a total unit built in as a gift shop. In fact, the hospitals in Washington nearly all have gift shops. They serve a very useful purpose. Their purpose is even therapeutic in many instances to the patients. The patients who are ambulatory in the hospital can go to an area of the hospital where a concession has been given for the gift shop, and very frequently would benefit greatly.

Mr. BUSBEY. You have raised another question. How many patients are you going to have in the food center building?

Dr. CRONIN. This food center building is on the campus, not more than 50 yards from 1 hospital and 85 to 100 yards from another hospital, and many of the patients in those hospitals will be ambulatory, and since it is in a university setting they will be able to come to this centralized gift shop to get little trinkets and favors that they may want to give to another patient, and to get little personal things that they may want themselves.

Mr. BUSBEY. Be sure in making up the tables to deduct the square feet that are contained in the corridors.

(The information referred to is as follows:)

Indiana Medical School food service building

Cost of entire building	$4, 202, 054
Cost of present Federal project	2, 904, 471
Federal share present project	1, 452, 235
Estimated cost of adjusted Federal project	2, 004, 085
Federal share of adjusted project	1, 002, 041
Square-foot area of entire building	162, 460

	Square-foot area of Federal project at present	Square-foot area participated in by Federal project after proposed adjustment
I. Storage for all hospitals	4, 330	4, 330
II. Preparation of food and related storage	19, 900	15, 920
III. Corridors, service areas, and miscellaneous	35, 545	27, 014
IV. Cafeteria (basement) and related areas	17, 135	12, 337
V. Gift shop	6, 760	4, 056
VI. Lounge and lobby	5, 130	513
VII. Conference room, printing, barber shop, beauty shop, and two apartments on mezzanine floor	4, 755	None
Total	93, 555	64, 170

HISTORY OF PROJECT

Mr. BUSBEY. Did your office always look with favor on this project?

Dr. CRONIN. This project, Mr. Chairman, was approved by the State of Indiana as an eligible project under the Hill-Burton program act. It was approved by the regional office in Chicago. We have had extensive correspondence about the scope of this project. We currently have this project under consideration, and there is a meeting to be held in Indianapolis on the 31st of this month, at which time will be represented the State agency, the sponsors of the project, which is the University of Indiana, and our regional people from Chicago, and representatives from our office headquarters, to discuss the Public Health Service's opinion concerning the scope of this project.

I might advise you that we have questioned the extensiveness of the project as approved, and we have taken the necessary steps to peel down, in the vernacular, this project to a position where we think it is justifiable. I should say that we do feel that everything which we have permitted to remain in the scope of this project is entirely justifiable under the administration of the Hill-Burton Act.

Mr. BUSBEY. Was it considered at the time this project was first proposed that it would serve as a food center exclusively for the LaRue-Carter Hospital at the University of Indiana Medical Center?

Dr. CRONIN. No; I do not think so. I think the thinking all the way along has been this project would be a food service center not only for the LaRue-Carter Hospital, but for the other hospitals such as the James Whitcomb Riley Hospital and so on at that campus.

Mr. BUSBEY. Then as the project has developed and stands at the present time, it is the same as it was originally planned?

Dr. CRONIN. I cannot answer that question. There has been so much discussion and activity relating to that project over the past several years—revisions of the project which is accordance with law—the project can be revised—that I could not tell you at this

time without having the file here with me. We can supply to you, sir, if you wish, a complete rundown narrative on that project.

Mr. BUSBEY. I do not think that is necessary. I was just a little curious about it.

Dr. CRONIN. I think that we have the situation well under control.

CARRYOVER OF APPROPRIATIONS

Mr. BUSBEY. Your request for this year is for $75 million?

Dr. CRONIN. That is correct.

Mr. BUSBEY. How much of that will carry over into future years?

Dr. CRONIN. We have a 2-year period in which this money can be spent under the provisions of the act. We do not provide for any amount of money to be carried over. We could not answer that question until a specific date in relation to what the States have done up to that time.

Mr. BUSBEY. In your justifications you mentioned the 2-year period, but the language of the appropriation bill says:

> For payments for hospital construction under part C, title 6, of the act, as amended, to remain available until expended.

Dr. CRONIN. It is a 2-year period for obligation. It is an open-end appropriation as far as final expenditures are concerned, under the act. In other words, we make the allotment to the State.

Mr. BUSBEY. Then, would not this $75 million be considered a carryover until expended?

Dr. CRONIN. Yes; in that light it is considered a carryover until expended, but each State has a period of 2 years in which to make the allotment we give them covered by projects. At the end of that time, if they have not covered that allotment given to them at the beginning of the 2-year period, the money is not available to them for future years and would revert to the Treasury of the United States.

Mr. HARLOW. I think that I can clear up the point that you have in mind. On page 189 of the committee print, in the table there that shows the amounts available for obligation, you will see that the 1954 estimate contemplates a total availability of $95 million, made up of two items, the $75 million that is proposed in our budget and a $20 million prior-year balance, which would be the amount that would carry over from 1953 into 1954, which has not yet lapsed; and that of the $75 million appropriated in 1954, $20 million will carry over into 1955, but still not be lapsed, so that our net obligations incurred during the 1954 fiscal year will be $75 million.

Mr. BUSBEY. I think that is the answer I was trying to get, Mr. Harlow.

Dr. CRONIN. I would like to add to Mr. Harlow's statement that a considerable portion of that $20 million is covered by part 1, that the States have allotted the funds to the communities but the planning and the development of the project have not reached a stage where the part 4 of the contract document is signed, so it is not really a free balance of $20 million available for utilization at all. It is committed money.

Mr. BUSBEY. It really would be a liquidation of contract authorization, then, would it not?

Dr. CRONIN. No. It is just money that has not yet been covered in final form by way of a firm contract as distinguished from money that has been covered by way of a firm contract.

Mr. HARLOW. I think perhaps a better answer to that question would be that, as far as the Federal Government is concerned, we have been committed to the States, but that the States have not yet reached the construction stage and we do not put an obligation on the books until the project is ready to go under construction.

Mr. STEPHENS. Our vernacular on this has been that that $20 million is committed but not encumbered. We have told them "Here it is," and they began to make their plans and get ready to use it. Until they complete the plans and get ready, the money is not actually obligated, or encumbered on the books.

UNLIQUIDATED OBLIGATIONS

Mr. BUSBEY. What is the total unliquidated obligation?

Mr. STEPHENS. $19,700,000.

Mr. BUSBEY. I mean overall, for the whole program.

Mr. HARLOW. If the amount that we are requesting to be appropriated for liquidating cash for 1954 is allowed——

Dr. CRONIN. $122,200,000 cash will carry over into 1955.

Mr. BUSBEY. Then, adding the $20 million to that, there would be about $132 million of total unliquidated obligations. Am I right?

Dr. CRONIN. That is very close.

STATUS OF AUTHORIZATIONS AND APPROPRIATIONS

Mr. BUSBEY. In view of the confusion on financing which results from there having been three types of appropriations in this program—contract authority, obligational cash, and liquidating cash—it might be well to have the table on page 68 of the justifications put into the record at this point.

It would be well to insert before that table the statement on liquidation of contract authorizations.

(The table and statement referred to are as follows:)

Mr. Chairman and members of the committee, in the past 6 years the Congress has authorized in the form of contract authorizations or cash authorization the sum of $542,500,000 for the construction phase of the Hill-Burton program. This is illustrated in chart A. To date, the Congress has appropriated $522,200,000. This represents a difference of $20,300,000. However, in a few instances, the States have not utilized every dollar allocated to them, and in completing final auditing of projects small sums of money are saved on behalf of the Government. The printed budget request indicates that $19,804,000 is required for the liquidation of obligations incurred under the contractual authorizations for previous years. We have carefully reviewed the request and are convinced that the request can be reduced by $104,000. The adjusted request is $19,700,000. With the appropriation of this amount, the program would be put on a complete cash basis, and there would be no future fund requests under this particular appropriation title.

Summary of projects, allocations and payments by fiscal years

Fiscal year	Number of projects given final approval	Allocations to States	Appropriations for Federal payments	Federal payments
1948	44	[1] $75,000,000	[2] $15,000,000	$392,183
1949	457	[1] 75,000,000	[2] 40,000,000	9,293,145
1950	460	[1] 150,000,000	[2] 40,000,000	57,828,930
1951	491	[3] 85,000,000	[4] 110,000,000	108,330,090
1952	258	[5] 82,500,000	[6] 182,500,000	121,622,467
1953	[7] 250	[8] 75,000,000	[8] 134,700,000	119,533,185
1954	[7] 200	[8] 75,000,000	[9] 94,804,000	87,804,000
Total	2,160	617,500,000	617,004,000	504,804,000

[1] Contract authority.
[2] Liquidating cash.
[3] $75,000,000 contract authority and $10,000,000 obligational cash.
[4] $100,000,000 liquidating cash and $10,000,000 obligational cash.
[5] Obligational cash.
[6] $100,000,000 liquidating cash and $82,500,000 obligational cash.
[7] Estimated.
[8] $59,700,000 liquidating cash and $75,000,000 obligational cash.
[9] $19,804,000 liquidating cash and $75,000,000 obligational cash. (The $19,804,000 is budgeted under the title "Grants for hospital construction (liquidation of contract authorization), Public Health Service.")

Source of allocations to States [1]

Fiscal year	Contract authority	Appropriations	Total
1948	$75,000,000	0	$75,000,000
1949	150,000,000	0	150,000,000
1950	300,000,000	0	300,000,000
1951	375,000,000	$10,000,000	385,000,000
1952	375,000,000	92,500,000	467,500,000
1953	375,000,000	167,500,000	542,500,000
1954 (estimate)	375,000,000	242,500,000	617,500,000

Appropriations [1]

Fiscal year	For liquidation	For obligations	Total
1948	$15,000,000	0	$15,000,000
1949	55,000,000	0	55,000,000
1950	95,000,000	0	95,000,000
1951	195,000,000	$10,000,000	205,000,000
1952	295,000,000	92,500,000	387,500,000
1953	354,700,000	167,500,000	522,200,000
1954 (estimate)	374,504,000	242,500,000	617,004,000

[1] Amounts accumulated.

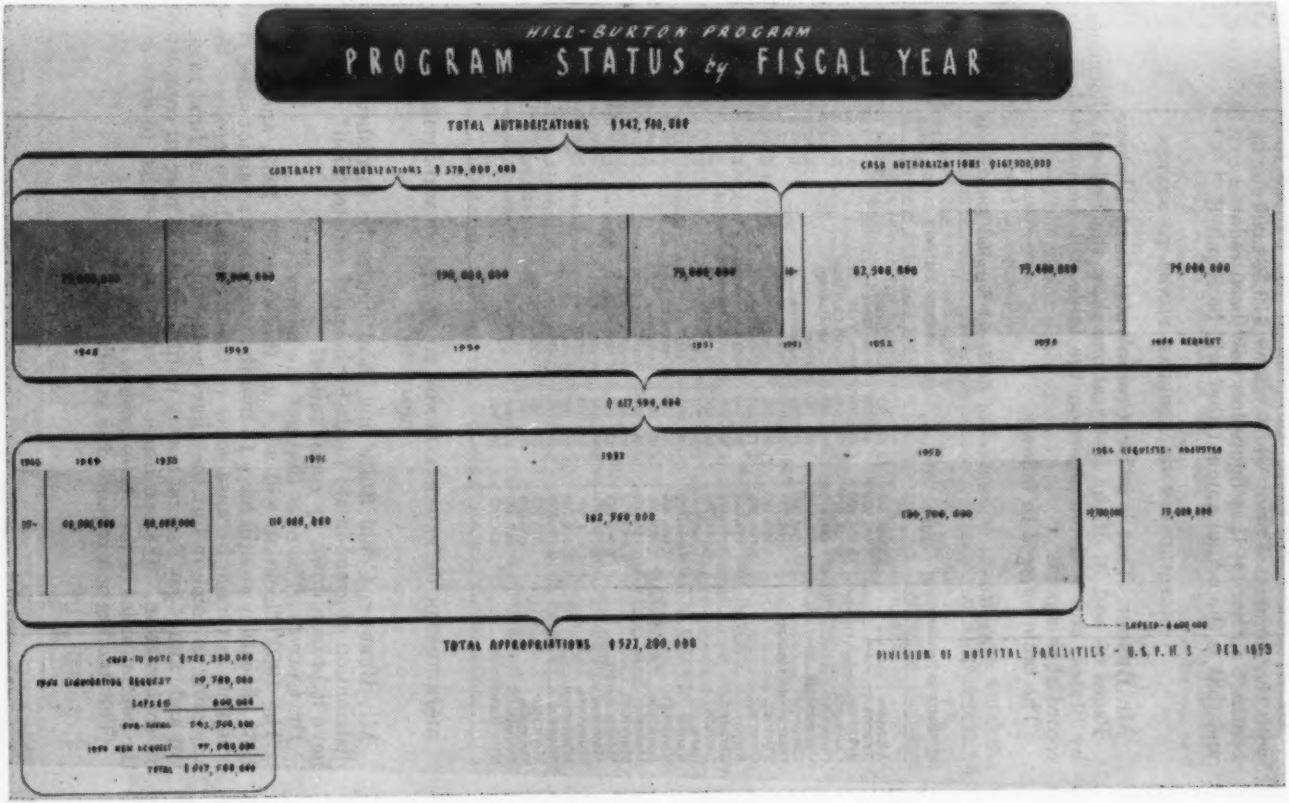
Dr. CRONIN. May I suggest also that this chart that I have here in my hand might clarify the situation? It diagrammatically indicates the period of time when the program was on a contract-authorization basis, the area that was on a cash-authorization basis, and shows the total authorizations and total appropriations, and I think very clearly indicates the relationship between the authorization, the cash appropriated by Congress during the respective years to cover the authorizations, the current situation, where we are today, with the $19,700,000 differential between the total appropriation and the total authorization.

Mr. BUSBEY. Can you reduce that chart to a table?

Dr. CRONIN. That is a reduction of the table to graphic form.

Mr. BUSBEY. We will insert the chart in the record at this point.

(The chart referred to is as follows:)


HILL-BURTON PROGRAM
PROGRAM STATUS by FISCAL YEAR
TOTAL AUTHORIZATIONS $942,500,000
CONTRACT AUTHORIZATIONS $ 370,000,000
CASH AUTHORIZATIONS $167,500,000
1948
1949
1950
1951
1952
1953
1954 REQUEST
$ 617,594,000
1948
1949
1950
1951
1952
1953
1954 REQUEST - ADDITIVE
TOTAL APPROPRIATIONS $922,200,000
DIVISION OF HOSPITAL FACILITIES - U.S.P.H.S. - FEB. 1953

Mr. STEPHENS. To avoid confusion, if you happen to be working with the committee print which shows $19,804,000 for liquidation of contract authority, that figure has now been reduced to $19,700,000, and that is the actual amount that will be required.

DISTRIBUTION OF FEDERAL FUNDS TO STATES

Mr. BUSBEY. That is in Dr. Cronin's statement I believe.

Pages 69 and 70 of the justifications show the Federal allocations by States, and without objection the table will be inserted in the record at this point.

(The table referred to follows:)

Distribution of grant-in-aid funds for hospital construction

State or Territory	1952 allocation	1953 allocation	State or Territory	1952 allocation	1953 allocation
Alabama	$3,014,588	$2,674,162	New Jersey	$1,604,722	$1,557,402
Arizona	483,702	463,728	New Mexico	539,397	521,666
Arkansas	1,885,430	1,685,566	New York	3,575,887	3,237,309
California	2,758,014	2,565,659	North Carolina	3,715,001	3,379,249
Colorado	581,476	539,688	North Dakota	264,285	230,635
Connecticut	621,996	564,189	Ohio	3,292,080	2,985,375
Delaware	200,000	200,000	Oklahoma	1,708,338	1,548,466
District of Columbia	204,735	200,000	Oregon	577,949	528,592
Florida	1,893,140	1,806,581	Pennsylvania	4,711,853	4,234,841
Georgia	3,068,889	2,774,251	Rhode Island	357,383	319,776
Idaho	324,984	291,180	South Carolina	2,080,814	1,865,785
Illinois	2,695,593	2,438,910	South Dakota	315,141	279,264
Indiana	2,034,798	1,865,636	Tennessee	2,954,710	2,661,875
Iowa	1,346,525	1,205,231	Texas	5,011,244	4,640,780
Kansas	1,081,829	989,639	Utah	415,457	381,661
Kentucky	2,685,339	2,379,780	Vermont	259,609	229,146
Louisiana	2,251,098	2,066,930	Virginia	2,446,564	2,230,318
Maine	621,258	541,997	Washington	1,020,065	929,243
Maryland	1,020,721	950,170	West Virginia	1,524,191	1,355,066
Massachusetts	2,061,948	1,859,157	Wisconsin	1,703,089	1,540,051
Michigan	2,662,947	2,444,644	Wyoming	200,000	200,000
Minnesota	1,674,461	1,502,369	Alaska	200,000	200,000
Mississippi	2,404,732	2,161,135	Hawaii	249,930	222,220
Missouri	2,186,873	1,907,746	Puerto Rico	2,487,331	2,228,307
Montana	207,113	200,000	Virgin Islands	30,021	26,809
Nebraska	668,609	607,828			
Nevada	200,000	200,000	Total	82,500,000	75,000,000
New Hampshire	324,081	289,988			

DISTRIBUTION OF FEDERAL FUNDS TO STATES, COMMUNITIES, AND PROJECTS

Mr. BUSBEY. Could State and local figures be furnished on the distribution of grant-in-aid funds for hospital construction? Do you have it broken down by communities?

Dr. CRONIN. The ones that got the money?

The 1952 allocation will wind up this June 30, 1953, and on the 1953 allocation we still have 16 months to go, so we cannot show you complete coverage because some of those States have projects that are going to come in but they have not completed their fund raising yet and cannot get Federal money until they are 25 percent completed on construction. We can insert for you the project list to date and the communities in the States broken down.

(The information requested is as follows:)

HOSPITAL FACILITIES DIVISION REPORT, DECEMBER 31, 1952

(Complete listing of hospitals, health centers, and facilities approved for Federal construction funds under the Hill-Burton program Federal Security Agency, Public Health Service

This report contains a complete list of hospitals, health centers, and facilities approved for Federal construction funds under the Hill-Burton program and three tables summarizing the status of all projects to date.

EXPLANATORY NOTES

The following defines the codes used in the listing of projects:

Status.—The status of a project is indicated as follows:

1. Approved but not yet under construction
2. Under construction
3. Completed and in use

Location.—The location is the name of the city, town, or village in which the project is physically located or the nearest post-office address which serves to identify it. Locations are listed alphabetically within a State.

Name.—The name used is that indicated by the project sponsor in the official application. Where a name has not been indicated in the application, the name to which the project is referred to in correspondence has been used.

Categories.—The various categories are indicated as follows:

1. General
2. TB
3. Mental
4. Chronic
5. Public-health center
6. Auxiliary Public-health center
7. General and Public-health center
8. State health department laboratory

*Adjunct services

An asterisk always appears in conjunction with another category. Thus, 1* indicates that an adjunct service, such as laboratory, nurses' home, outpatient department, service facility, or other related facility is being constructed.

Type of construction.—The type of construction is indicated as follows:

1. New
2. Addition
3. Remodeling
4. Replacement
5. Addition and remodeling
6. Addition and replacement
7. Addition, remodeling, and replacement
8. Remodeling and replacement

Beds added.—Includes all additional beds for patients in the cost of which the Federal Government participates.

Estimated total cost.—Includes the estimated cost of constructing and equipping the total facility.

Approved Federal share.—Includes the amount of Federal participation.

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	ALABAMA						
2	Aliceville	South Pickens County Hospital	1	1	30	$344,685	$218,390
3	Ashland	Clay County	1	1	20	270,102	175,034
3	Athens	Athens Limestone County	1	1	50	672,134	439,241
3	Birmingham	Carraway Methodist	*1	2		554,443	184,815
3	Do	365 Crippled Child Clinic	1	1	100	1,876,969	566,018
3	Do	St. Vincents	1	2	90	1,559,473	453,206
3	Do	University of Alabama Memorial Dental Clinic	1	2		2,523,721	420,811
3	Do	Jefferson County Public Health Center	*5	1		951,874	317,291
2	Brewton	Escambia County	1	1	35	569,685	363,123
2	Chatom	Washington County	1	1	20	369,918	246,612
3	Cullman	Cullman Health Clinic	5	1		99,163	66,016
3	Decatur	District No. 1 TB Sanatorium	2	1	161	1,144,693	754,984
2	Demopolis	Bryan Whitfield Memorial	1	1	29	379,977	253,318
2	Ensley	Holy Family	1	1	62	924,449	597,904
1	Enterprise	Enterprise Health Center	5	1		90,000	60,000
1	Eufaula	Barbour County	1	1	50	760,000	500,000
2	Evergreen	Conecuh County Hospital	1	1	31	441,857	291,238
2	Fayette	Fayette County Health Center	5	1		94,861	63,241
1	Florence	Lauderdale County Health Center	5	1		134,000	76,000
3	Fort Payne	De Kalb County General	1	1	55	606,235	400,554
1	Gadsden	District No. 4 TB Sanatorium	2	1	140	1,230,000	800,000
3	Do	Etowah County Health Center	5	1		359,681	119,880
3	Hamilton	Marion County	1	1	37	451,645	286,363
2	Huntsville	Madison County Public Health Center	5	1		166,499	110,999
3	Langdale	George H. Lanier Memorial	1	1	87	2,160,398	719,009
3	Livingston	Sumter County Health Center	5	1		109,601	68,554
3	Marion	Perry County	1	1	20	225,386	73,438
3	Mobile	Martin de Porres	1	1	35	611,425	195,475
3	Do	Mobile Infirmary	1	1	300	4,368,580	2,781,509
3	Do	Providence	1	1	200	3,375,956	2,000,000
3	Do	Psychiatric Receiving and Diagnostic Unit	3	2	20	138,001	45,000
1	Montgomery	State Health Building	8	1		600,000	400,000
3	Do	St. Jude	1	1	152	1,345,067	438,663
2	Moulton	Lawrence County	1	1	40	596,111	392,074
2	Oneonta	Blount County	1	1	30	525,345	346,897
3	Opelika	Lee County Hospital and Health Center	7	1	80	1,040,211	653,340
3	Opp	Mizell Memorial	1	1	29	470,998	153,666
3	Ozark	Dale County	1	1	50	572,672	381,029
2	Reform	North Pickens County Hospital	1	1	30	336,572	216,315
2	Roanoke	Randolph County	1	1	35	517,027	342,885
1	Russellville	Franklin County Health Center	5	1		108,000	72,000
3	Selma	Dallas County Health Center	5	1		190,230	37,634
3	Sylacauga	Hospital Nurses' Home and Training School	1	1		336,407	219,770
2	Tuscaloosa	Druid City	*1	1	241	3,197,632	1,952,817
3	Do	Bryce	3	2	125	346,408	230,137
3	Tuskegee	Macon County	1	1		169,670	23,780

3	Tuskegee	Macon County	1	1				
3	Union Springs	Bullock County	1	1	28	320,804	206,143	
3	Vernon	Lamar County	1	1	30	455,702	298,802	
	ARIZONA							
2	Casa Grande	Casa Grande Valley	1	1		258,460	23,230	
3	Florence	Pinal General	1	5	14	59,319	19,773	
3	Do	do	1	5	18	199,970	99,985	
3	Globe	Gila County	1	5	33	599,938	299,969	
3	Phoenix	Maricopa County	1	2	100	247,000	100,000	
1	Do	St. Lukes	*2	2	64	528,061	78,445	
1	Do	St. Josephs	1	1	375	5,828,089	1,500,000	
2	Do	Good Samaritan	1	5	100	1,307,560	494,610	
2	Do	Maricopa County	1	2	61	669,077	157,339	
3	Do	St. Johns Community HC	1	1		95,379	11,510	
3	St. Johns	St. Marys Hospital and Sanitorium	1	5	120	1,600,272	533,424	
3	Tucson	Williams Community	1	1		116,546	10,516	
3	Williams	Winslow Memorial	*1	1	24	199,724	99,862	
1	Winslow							
	ARKANSAS							
3	Arkadelphia	Clarke County	1	1	30	291,300	93,715	
3	Benton	State Nervous and Mental	*3	5		135,107	45,036	
3	Do	do	*3	1		277,933	92,644	
3	Do	do	*3	1	400	1,576,526	525,508	
2	Blytheville-Osceola	Mississippi County	1	1	82	843,907	364,157	
2	Brinkley	Mercy Gazzola Memorial	1	1	50	598,787	399,191	
3	Camden	Ouachita County	1	1	100	1,591,216	997,021	
3	Clinton	Van Buren County	1	1	12	157,538	93,601	
3	Crossett	Crossett Health Foundation	*1	1	52	748,581	246,542	
3	Dumas	Desha County	1	1	42	278,605	92,868	
3	El Dorado	Warner Brown Training School	*1	5	57	2,480,216	1,653,477	
3	Fayetteville	Washington County Memorial	*1	1	49	451,368	150,456	
2	Fort Smith	Sparks Memorial	1	6	150	1,974,580	1,184,748	
2	Do	St. Edwards Mercy	1	5	60	2,225,064	1,483,376	
3	Harrison	Boone County	1	1	50	467,300	153,329	
2	Little Rock	St. Vincent Infirmary	1	2	340	6,169,639	3,762,393	
2	Do	University of Arkansas Medical Center	1	1	400	8,301,662	2,400,000	
3	Do	State Nervous and Mental	*3	1		148,726	49,575	
3	Do	do	*3	1		212,717	70,906	
3	Do	State Mental TB Unit	3	2	100	776,766	258,922	
3	Malvern	Hot Springs County Memorial	1	1	40	295,376	98,459	
3	Mena	Polk County Memorial	1	1	30	324,157	106,264	
3	Monticello	Drew County	1	1	60	438,229	140,043	
3	Morrilton	St. Anthonys	1	2	29	223,104	74,368	
3	Paragould	Community	1	1	66	242,902	80,967	
3	Pocahontas	Randolph County	*1	1	32	274,441	88,353	
3	Rison	Cleveland County	7	1	18	275,228	161,341	
3	Rogers	Rogers Memorial	1	1	25	263,564	82,355	
2	Springdale	Springdale Memorial	1	1	50	599,172	399,408	
3	Van Buren-Crawford	Ford County	1	1	52	577,925	321,215	
3	Warren	Bradley County	1	1	44	507,753	294,452	
3	West Memphis	Crittenden County	1	1	90	1,252,238	415,842	
3	Wynne	Cross County	1	1	50	498,244	332,163	

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	CALIFORNIA						
3	Alturas	Modoc General	1	1	39	$841,000	$275,000
1	Bakersfield	Greater Bakersfield Memorial	1	1	103	2,003,931	646,977
1	Do	Mercy	*1	6	58	1,277,841	425,947
3	Banning	San Gorgonio Pass Memorial	1	1	37	591,501	183,300
3	Bishop	Northern Inyo	1	1	30	473,230	155,327
3	Brawley	Pioneers Memorial	1	1	100	1,566,019	491,598
2	Burbank	St. Josephs Hospital	1	2	141	1,907,300	560,896
2	Calexico	Municipal	1	1	20	372,600	124,200
2	Chester	Seneca District	1	1	10	338,912	112,971
3	Corcoran	Corcoran Municipal	*1	1		48,004	16,001
2	Corning	Corning Memorial	7	1	25	426,411	140,470
3	Dinuba	Alta	7	1	50	812,516	266,805
3	Escondido	Palomar Memorial	1	1	37	466,328	155,442
2	Eureka	St. Joseph Hospital	1	1	92	1,662,708	554,236
1	Fresno	Fresno County TB Hospital	2	1	194	2,000,000	500,000
2	Do	County Health Center	5	1		649,492	216,497
3	Gridley	Biggs Gridley Memorial	1	1		370,385	16,248
2	Hanford	Kings County Public Health Center	5	5		149,967	49,989
2	Hawthorne	Hawthorne Community	*1	2	43	516,762	172,254
2	Hayward	Eden Township District	1	1	118	4,031,155	1,022,494
3	Hemet	Hemet Valley	1	5	10	265,543	88,514
3	Hollister	San Benito County Health Center	5	1		43,776	14,592
2	Hondo	Rancho Los Amigos	*4	2	198	1,697,795	240,000
1	Independence	Inyo County Health Center	5	1		54,200	18,067
1	Inglewood	Centinela Valley Community	*1	2		364,309	116,967
2	Do	Daniel Freeman Memorial	1	1	102	1,913,822	632,941
3	Do	Centinela Valley Community	1	6	39	196,505	62,498
2	Jackson	Amador County	7	1	35	495,336	164,496
2	Lodi	Memorial	1	1	57	1,167,925	329,917
1	Lone Pine	Southern Inyo	1	1	18	296,972	96,557
1	Los Angeles	Westchester Health Center	5	1		115,500	38,500
3	Loyalton	Sierra Valley	1	1	10	180,415	59,722
3	Madera	Madera County Health Center	5	1		53,381	17,794
3	Mariposa	John C. Fremont	1	1	20	418,717	126,433
3	Merced	County	1	2	88	1,129,760	376,587
3	Modesto	Memorial Stanislaus County	1	1	92	1,211,575	400,000
3	Do	Stanislaus County Central Unit	*1	2	17	1,444,818	323,772
3	Needles	Municipal	1	5	10	282,060	89,672
3	Oroville	Butte County Primary Health Center	5	1		58,651	19,550
2	Oxnard	St. John's	1	4	75	1,595,863	531,954
3	Paso Robles	Paso Robles War Memorial	1	1	24	598,051	199,350
3	Patterson	Patterson Hospital District	1	1	25	445,254	145,160
2	Redding	Mercy	1	1	75	1,442,417	430,321
2	Do	Cascade Sanitorium	2	1	63	894,791	298,264
2	Richmond	West Contra Costa District	1	1	100	3,884,157	913,282
3	Roseville	Roseville Municipal	1	1		277,950	17,009

3	San Andreas	Mark Twain	1	1	30	627,540	209,180
1	Do		4	1		146,000	48,667

2	Richmond	Roseville Municipal					
3	Roseville						
3	San Andreas	Mark Twain	1	1	30	627,540	209,180
3	San Francisco	Maimonides Health Center	4	1		146,000	48,667
2	San Jose	O'Conner	1	1	250	4,883,978	1,600,000
2	Do	General	1	5	64	1,289,823	425,941
2	Do	Santa Clara County Health Center	5	1		480,476	143,599
1	San Leandro	Alameda County Health Center	5	1		350,543	116,848
3	San Luis Obispo	San Luis Obispo Public Health Center	5	1		115,525	33,454
1	San Rafael	Marin County Public Health Center	5	1		144,820	48,273
3	Do	Marin District	5	1		1,825,702	576,920
3	Tracy	Tracy Community Memorial	1	1	108	227,979	73,583
3	Truckee	Tahoe Forest District	1	1	42	403,238	127,747
3	Tulare	Tulare District	1	1	21	1,299,500	416,500
3	Ventura	Foster Memorial	1	1	73	415,805	138,602
3	Weaverville	Trinity County	1	5	20	352,215	117,405
3	Willows	Glenn County	1	1	20	633,824	211,275
			1	1	42		
	COLORADO						
		Washington County	1	1	20	257,732	85,853
3	Akron	Aurora Health Center	1	1		40,200	17,420
1	Aurora	Community	6	1		505,598	216,492
1	Boulder	Memorial	*1	5	43	238,480	78,094
3	Craig	St. Joseph's	1	1	18	637,584	276,286
1	Del Norte	Memorial Hospital Association	1	1	40	219,605	58,389
3	Delta	Mercy	1	1	27	928,339	387,764
2	Durango	Arapahoe County Public Health Center	7	5	44	64,166	27,805
2	Englewood	Community	6	1		507,732	216,334
3	Fort Morgan	St. Mary's	1	1	40	2,273,483	753,981
3	Grand Junction	Weld County	1	1	130	2,708,988	900,000
3	Greeley	Sedgwick County Public	7	1	111	254,051	108,392
3	Julesburg	Memorial	1	1	18	640,119	276,908
3	Loveland	do	1	1	40	486,619	158,677
3	Montrose	Pioneers Memorial	1	1	50	444,383	192,133
1	Rocky Ford	Steamboat Springs	7	1	25	61,652	55,582
3	Steamboat Springs	Ira Taylor Health Center	1	1		149,980	64,991
1	Sterling		5	1			
	CONNECTICUT						
		Griffin	*1	5	64	1,157,685	200,000
2	Derby	Hartford	*1	2		561,406	187,136
3	Hartford	City of Hartford Public Health Center	5	3		35,367	11,786
3	Do	Manchester Memorial	1	5	44	974,959	300,000
3	Manchester	Meriden	1	5	116	1,300,000	300,000
2	Meriden	Middlesex	1	5	80	1,251,828	300,000
2	Middletown	New Britain	1	5	37	2,052,968	200,000
2	New Britain	Grace-New Haven Community	*1	5		7,895,707	200,000
2	New Haven	Public Health Center	1	1		6,271	2,090
3	New London	New Milford	5	3		675,000	225,000
3	New Milford	Norwalk	1	1	40	1,821,748	200,000
2	Norwalk	Wm. H. Backus	*1	5	41	156,757	52,252
2	Norwich	Day Kimball	1	5	14	900,000	300,000
2	Putnam	Sharon	1	5	58	103,680	34,560
3	Sharon	Stamford Hospital	1	5		2,000,000	200,000
2	Stamford	St. Mary's	*1	5	75	1,085,750	200,000
2	Waterbury	Waterbury Hospital	*1	5	34	1,925,630	200,000
2	Do	Windham Community Memorial	*1	2		600,000	200,000
2	Willimantic		1	7	40		

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	DELAWARE						
3	Dover	Kent General	1	5	40	$657,887	$228,166
2	Farnhurst	Delaware State	3	5	234	719,830	270,656
1	Marshallton	Brandywine Sanatorium	2	2	76	1,808,250	343,012
2	Milford	Milford Memorial	*1	6	31	960,993	361,333
2	Seaford	Nanticoke Memorial	1	1	30	523,492	196,833
	DISTRICT OF COLUMBIA						
2	Washington	Children's Hospital	*1	7	98	2,714,768	814,929
3	Do	Gallinger Municipal	1	2	54	2,432,909	525,914
	FLORIDA						
3	Bonifay	Holmes County Health Center	6	1		41,911	27,242
2	Bradenton	Manatee Veterans Memorial	1	1	100	1,257,400	503,700
2	Chattahoochee	Florida State	3	2	100	708,847	354,424
3	Chipley	Washington County	1	1	28	255,457	166,047
2	Crawfordville	Wakulla County Health Center	6	1		102,847	61,708
3	Crestview	Okaloosa County Health Center	6	1		41,950	27,268
3	De Funiak Springs	Walton County	1	1	30	272,501	88,634
2	Deland	The Fish Memorial Hospital	1	1	50	817,436	257,243
1	Fort Lauderdale	Broward General	1	2	86	800,000	280,000
1	Fort Myers	Lee Memorial	*1	2	35	400,000	180,000
2	Hollywood	Memorial Hospital	*1	1	102	863,896	192,500
1	Jacksonville	St. Vincents	*1	5	126	1,108,556	187,500
1	Do	St. Lukes	1	2	28	275,000	68,750
1	Do	Hope Haven	*4	5	25	184,250	75,000
1	Do	District Laboratory and Public Health Center	8	1		350,000	175,000
3	Do	St. Lukes	*1	5		191,763	63,921
3	Do	do	1	5	31	333,783	150,202
3	Do	Duval County	3	1	40	443,815	129,421
3	Lantana	Southeast Florida Sanatorium	2	1	500	3,710,051	1,189,761
3	Live Oak	Suwannee County Hospital	1	1	36	308,242	93,686
1	Madison	Madison County	1	1	25	302,737	172,042
2	Marianna	Jackson Hospital	*1	5	13	156,576	101,775
2	Miami	Jackson Memorial	*1	2	195	4,538,317	1,263,500
3	Do	South Florida Children's	4	1	80	843,532	281,178
2	Milton	Santa Rosa County	7	1	23	420,204	273,133
1	Ocala	Munroe Memorial Hospital	*1	5	38	693,500	300,000
3	Orlando	Orange Memorial	*1	5	43	786,724	276,007
3	Panama City	Bay County	1	1	58	616,152	195,433
3	Pensacola	Baptist Memorial	1	1	158	1,555,390	855,464
2	Plant City	South Florida Baptist	1	1	100	1,183,511	439,784
3	Quincy	Gadsden County	1	1	69	956,841	528,650
1	Sanford	Fish Memorial	1	1	50	767,000	270,000
1	Sarasota	Sarasota	*1	5	53	1,220,000	350,000
3	St. Petersburg	American Legion Crippled Children's	4	1	61	777,275	258,497

1	Sarasota	American Legion Crippled Children's	4	1	61	777,275	288,497
3	St. Petersburg						

3	Tallahassee	Florida Agricultural and Mechanical College	*1	1	100	1,923,119	641,040
3	Do	Tallahassee Memorial	*1	1	150	2,007,038	483,640
3	Do	W. T. Edwards Sanatorium	2	1	350	2,822,310	780,133
3	Tampa	St. Joseph's	1	2	73	711,449	237,604
3	Vero Beach	Indian River Memorial	1	1	30	507,107	164,593
3	Winter Garden	West Orange Memorial	*1	1	35	207,508	125,796
1	Winterhaven	Polk County Health Center	5	1		88,500	35,400
		GEORGIA					
3	Adamsville	Fulton County Public Health Center	6	1		43,001	14,334
3	Adel	The Memorial	1	1	25	193,800	116,280
2	Alma	Beacon County	1	1	30	329,000	180,950
3	Alpharetta	Fulton County Public Health Center	6	1		37,654	12,551
2	Americus	Americus-Sumter County	1	1	100	1,339,000	736,450
2	Do	Americus Sumter Colored	*1	5	35	286,082	157,345
3	Arlington	Arlington City	1	1	16	158,900	95,340
2	Ashburn	Turner County	1	1	25	416,674	171,833
3	Athens	Athens General	1	1	22	552,900	184,300
3	Do	Athens-Clarke Health Center	*1	5		164,872	90,680
3	Atlanta	Grady Memorial Negro Unit	5	1		1,725,984	1,035,590
3	Do	Atlanta Health Center	1	2	116	476,881	158,969
2	Augusta	University of Augusta	5	1		1,067,000	480,150
2	Do	St. Joseph's	1	5		1,638,910	975,600
2	Do	Richmond County Health Center	1	1	110	426,620	191,979
3	Barnesville	Barnesville-Lamar County Health Center	5	1		165,372	90,955
3	Baxley	Baxley Appling County	7	1	11	257,196	154,318
2	Blackshear	Pierce County	1	1	27	340,564	153,254
1	Bremen	Bremen	1	1	25	360,000	120,000
1	Brunswick	Glynn County Health Center	1	1	25	147,500	49,167
2	Do	Brunswick City	5	1		1,098,600	494,370
3	Buckhead	Fulton County Public Health Center	1	1	75	38,726	12,909
3	Butler	Taylor County Health Center	6	1		23,730	13,052
2	Calhoun	Gordon County	6	1		639,302	275,156
1	Camilla	Mitchell County	1	1	40	129,480	43,160
3	Do	do	*1	2	18	268,139	89,380
3	Do	Mitchell County Nurses Home	1	1	32	42,903	14,301
3	Do	Mitchell County Health Center	*1	2		85,398	46,969
3	Carrollton	Tanner Memorial	5	1		528,000	176,000
2	Cedartown	Polk County Health Center	1	1	40	82,650	37,192
3	Do	Polk General	5	1		69,500	41,700
3	Center Hill	Fulton County Public Health Center	1	5	10	42,120	14,040
3	Chatsworth	Murray County Memorial	6	1		41,000	13,667
3	Claxton	Evans County Health Center	1	1		39,763	21,869
2	Clayton	Rabun County Health Center	6	1		65,200	35,860
3	Do	Rabun County	6	1		237,000	130,350
3	Collins	Fulton County Public Health Center	1	1	20	39,380	13,127
2	Columbus	Columbus City Hospital	6	1		212,003	95,401
3	Do	St. Francis	*1	4		1,909,807	636,602
2	Cordele	Crisp County	1	1	154	767,000	345,150
1	Covington	Newton County	1	1	50	554,736	182,246
2	Darien	McIntosh County Health Center	1	1	34	49,980	27,489
3	Dawson	Terrell County	6	1		255,868	153,520
3	Dawsonville	Dawson County Public Health Center	1	1	27	44,082	26,449
			6	1			

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	GEORGIA—continued						
3	Decatur	DeKalb County Public Health Center	5	1		$195,216	$65,072
3	Demorest	Habersham County	1	1	44	555,200	302,625
1	Douglas	Coffee County Health Center	5	1		84,070	28,023
2	Do	Coffee County	1	1	60	937,264	515,495
2	Douglasville	Douglas County Health Center	6	1		52,000	23,400
3	Dublin	Laurens County	1	1	60	896,068	487,337
1	Eatonton	Putnam County Health Center	5	1		71,010	23,670
3	Elberton	Elbert County	1	1	50	780,276	260,092
3	Do	Elberton-Elbert County Health Center	5	1		79,491	47,695
1	Ellijay	Watkins Memorial	1	1	25	361,902	119,967
3	Fairburn	Fulton County Public Health Center	6	1		40,696	13,565
2	Folkston	Charlton County Health Center	5	1		46,000	20,700
2	Fort Oglethorp	Tri-County Hospital	1	5	100	1,262,052	609,986
2	Fort Valley	Peach County	1	1	25	408,000	178,758
3	Franklin	Heard County Memorial	1	1		17,217	5,739
3	Gainesville	Hall County Memorial	1	1	112	1,666,228	536,102
3	Greensboro	Minnie G. Boswell Memorial	1	1	28	401,250	133,750
3	Greenville	Meriwether County Health Center	5	1		82,500	45,575
3	Griffin	Griffin-Spalding County	1	1	101	1,321,491	440,497
3	Do	Griffin-Spalding County Health Center	5	1		173,945	95,670
3	Hamilton	Harris County Health Center	6	1		33,800	20,280
1	Hartwell	Hart County Auxiliary Public Health Center	6	1		60,000	20,000
3	Hiawassee	Lee M. Happ, Jr., Memorial	1	1	12	179,604	98,782
3	Howell Mill	Fulton County Public Health Center	6	1		31,679	10,560
3	Irwinton	Wilkinson County Health Center	6	1		36,879	20,283
2	Jackson	Butts County Auxiliary Health Center	6	1		57,989	26,095
3	Jesup	Wayne County Public Health Center	5	1		87,508	52,505
3	Lagrange	City-County	1	2	74	504,000	168,000
3	Lakewood	Fulton County Public Health Center	6	1		37,935	12,645
2	Lawrenceville	Gwinnett County Health Center	5	1		119,215	65,568
3	Macon	Macon City	1	5		154,593	51,531
3	Do	do	1	2	24	57,834	19,278
1	Marietta	Kennestone	*1	2	50	750,000	250,000
3	Do	do	1	1	103	1,208,564	402,855
3	McRae	Telfair County	1	1	30	360,000	198,000
2	Millen	Jenkins County Auxiliary Public Health Center	6	1		51,749	23,287
2	Monroe	Walton County Health Center	5	1		93,271	41,972
3	Monticello	Jasper County	1	1	25	260,000	143,000
2	Moultrie	Vereen Memorial	1	5	24	787,941	308,772
2	Nashville	Berrien County Auxiliary Health Center	6	1		49,544	22,295
1	Newnan	Coweta County Health Center	5	1		95,000	31,667
2	Ocilla	Irwin County	1	1	25	328,775	147,949
3	Pearson	Atkinson County Health Center	6	1		20,392	11,216

3	Perkerson	Fulton County Public Health Center	6	1		38,190	12,730
2	Quitman	Brooks County Health Center	6	1		66,415	36,528
3	Red Oak	Fulton County Public Health Center	6	1		42,086	14,029
3	Richland	Stewart-Webster	1	1	24	255,536	85,179
3	Rockdale Park	Fulton County Public Health Center	6	1		32,901	10,967
2	Rockmart	Rockmart-Aragon	1	1	25	329,956	148,480
3	Rome	Battey State	*2	2		164,162	90,289
3	Do	do	*2	3		153,413	84,377
3	Do	Floyd County Public Health Center	5	1		65,226	35,874
3	Royston	Cobb Memorial	1	1	20	213,460	71,153
3	Sandy Springs	Fulton County Public Health Center	6	1		36,271	12,090
2	Soperton	Treutlen County	1	1	25	310,410	170,726
3	South Fulton	Fulton County Public Health Center	6	1		33,111	11,037
3	Springfield	Effingham County Health Center	6	1		38,367	21,102
1	Statesboro	Bulloch County	*1	2	30	600,000	200,000
3	Do	Bulloch County Health Center	5	1		61,470	33,809
3	Summerville	Chattooga County	1	1	31	345,000	189,750
3	Swainsboro	Emanuel County	1	1	50	591,790	355,074
3	Sylvania	Screven County General	1	1	34	332,000	199,200
3	Sylvester	Worth County	1	1	29	293,114	97,705
3	Thomaston	Upson County	1	1	100	1,122,000	374,000
1	Thomasville	John D. Archibold Memorial	*1	5	25	300,000	135,000
3	Do	Thomas County Health Center	5	1		163,250	89,788
3	Thomson	McDuffie County	1	1	29	325,500	195,300
2	Tifton	Tift County	1	5	30	371,120	167,004
3	Toccoa	Stephens County	1	5	5	424,000	254,400
2	Trenton	Dade County Health Center	6	1		53,250	23,962
2	Valdosta	Lowndes County	1	1	100	1,580,000	661,363
3	Watkinsville	Oconee County Health Center	6	1		43,500	23,925
3	Waynesboro	Waynesboro Burke County	1	1	33	416,070	249,642
3	Do	Burke County Health Center	5	1		61,822	34,002
1	Winder	Barrow County Health Center	5	1		64,230	21,410
3	Do	Barrow County	1	1	40	550,000	302,500
3	Woodbine	Camden County Public Health Center	6	1		45,714	25,143
	IDAHO						
3	Ashton	Ashton Memorial	1	1	15	90,387	30,129
3	Blackfoot	Bingham County	1	1	42	544,919	181,639
3	Boise	St. Alphonsus	1	2	60	903,503	105,000
3	Do	St. Luke's Hospital	1	5	79	970,276	105,000
2	Caldwell	Caldwell Memorial	1	1		86,014	28,671
3	Do	do	1	1	75	714,524	139,752
3	Gooding	Gooding Memorial	1	2	18	173,317	31,705
3	Jerome	Jerome Memorial	1	1	40	702,980	208,500
3	Montpelier	Bear Lake County	1	1	35	356,205	118,735
3	Pocatello	Pocatello General	*1	1	100	1,572,919	300,000
3	Do	St. Anthony Mercy	*1	5	25	434,712	23,572
3	Salmon	Steele Memorial	7	1	28	261,134	87,045
3	Twin Falls	Twin Falls County	1	1	161	1,853,773	315,029
3	Weiser	Weiser Memorial	1	1	30	450,335	145,554

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	ILLINOIS						
3	Aledo	Mercer County	1	1	50	$801,233	$267,078
3	Anna	Anna City	*1	1	50	1,161,976	387,325
2	Aurora	Mercyville Sanitarium	*3	2	100	2,030,950	589,950
2	Benton	Franklin Hospital	*1	1	100	1,640,000	644,880
2	Bloomington	St. Joseph's	1	2	40	392,738	147,440
2	Cairo	St. Mary's	1	2	65	1,200,000	465,600
3	Do	St. Mary's Nurses Home	*1	2		402,754	134,251
3	Carlinville	Carlinville General	1	1	53	912,000	353,856
2	Carmi	Carmi Township	1	1	50	1,069,000	414,772
3	Carthage	Hancock County	1	1	50	741,475	247,159
2	Chicago	Swedish Covenant	1	2	50	485,727	155,200
2	Do	Resurrection	1	1	175	3,849,363	1,435,600
2	Do	University of Chicago	1	2	151	3,633,839	535,440
2	Do	Department of Health Laboratory	8	5		119,926	46,531
3	Do	Provident Hospital Training School	1	5	30	527,000	204,476
3	Do	Illinois Masonic	1	2	70	1,008,302	160,428
3	Do	District Health Center	5	5		2,494	968
2	Effingham	St. Anthony's Memorial	1	1	125	4,356,149	1,690,186
3	Evanston	Community	1	4	50	940,000	364,720
3	Fairfield	Fairfield Memorial	1	1	100	1,242,983	414,328
3	Flora	Clay County	1	1	50	906,295	302,099
3	Gibson	Gibson Community	1	1	40	800,000	310,400
2	Highland Park	Highland Park	1	5	30	210,681	46,560
2	Hinsdale	Hinsdale Sanitarium and Hospital	1	4	197	3,314,633	1,241,600
2	Jacksonville	Passavant Memorial	1	1	136	2,015,000	763,393
1	LaGrange	Community Memorial General Hospital	*1	1	100	2,000,000	776,000
3	Lawrenceville	Lawrence County	7	1	50	971,100	323,700
2	Lincoln	Abraham Lincoln Memorial	1	1	104	1,765,000	659,600
2	Marion	Marion Municipal	1	1	56	947,000	367,436
3	Mount Carmel	Wabash County	1	1	52	904,963	301,654
3	Mount Vernon	Good Samaritan	1	1	100	2,199,000	733,000
3	Do	State TB Sanitarium	2	1	100	2,117,267	446,693
2	Olney	Medical Center, Richland County	1	1	100	1,690,000	655,720
1	Pekin	Pekin Public Hospital	*1	5	75	1,500,000	589,924
2	Peoria	The Methodist	1	1	84	1,690,145	407,400
3	Do	St. Francis, Forest Park	1	2		1,166,524	71,401
2	Quincy	Blessing	1	5	50	1,167,000	301,864
3	Red Bud	St. Clements	1	2	64	1,096,339	238,576
2	Rock Island	St. Anthony's	1	2	60	1,800,000	388,000
2	Shelbyville	Shelby County Memorial	1	2	24	435,000	168,780
2	Taylorville	St. Vincent Memorial	*1	1	117	2,468,000	861,393
1	Vandalia	Fayette County	1	1	82	1,526,000	589,924
	INDIANA						
3	Bedford	Dunn Memorial	1	5	40	560,944	183,629
3	Cannelton	Perry County Memorial	1	1	28	559,941	184,139

3	Bedford	Dunn Memorial	1	1	28	359,941	184,139	
3	Cannelton	Perry County Memorial						
2	Clinton	Vermillion County	1	5	36	389,680	194,840	
3	Columbia City	Whitley County Memorial	1	1	57	768,232	252,072	
2	Columbus	Bartholomew County	*1	5	62	1,696,261	837,925	
3	Connersville	Fayette Memorial	1	2	24	350,453	105,731	
3	Corydon	Harrison County	*1	1		4,768	2,384	
3	Do	do	7	1	18	317,828	102,491	
3	Dyer	Mount Mercy Hospital and Sanatorium	3	2	125	1,052,009	334,688	
3	Do	do	3	2	44	265,073	128,428	
2	Elkhart	Elkhart General	*1	2	45	1,457,668	619,500	
2	Evansville	Protestant Deaconess	1	2	54	695,031	347,210	
2	Fort Wayne	Methodist Hospital	*1	1	260	3,785,220	1,508,366	
2	Do	Irene Byron Sanatorium	2	5	50	626,878	312,119	
3	Do	Lutheran Hospital Nurses' Home	*1	4		815,321	164,599	
3	Do	Irene Byron TB Sanatorium	*2	2		146,318	47,328	
2	Frankfort	Clinton County	1	2	55	1,223,556	606,004	
2	Gary	Methodist	1	2	36	492,107	246,053	
3	Do	Gary Public Health Center	5	3		19,195	2,942	
1	Goshen	Goshen Hospital	7	1	50	825,000	412,500	
2	Greenfield	Hancock Memorial	*1	1	47	722,397	239,656	
2	Hammond	St. Margaret	1	2		336,493	160,935	
2	Indianapolis	Indiana University Medical Center	*1	2		4,202,054	1,452,235	
3	Jasper	DuBois County Memorial	*1	1	75	1,105,180	358,345	
3	Jeffersonville	Clarke County Memorial	1	1		51,129	11,244	
2	Knox	Starke County	*1	1	35	383,410	189,986	
3	LaGrange	LaGrange County	1	1	38	668,029	215,387	
2	Linton	Freeman Greene County	1	2	33	440,334	216,407	
2	New Albany	Floyd County	1	1	61	1,373,630	656,240	
3	Noblesville	Hamilton County Hospital	*1	1	83	1,062,987	332,884	
2	Portland	Jay County	1	5	44	914,832	452,759	
2	Richmond	Reid Memorial	1	5	100	1,721,133	860,566	
3	Rushville	Rush County	*1	1	63	897,311	290,336	
3	Salem	Washington County Memorial	1	1	27	543,734	179,176	
2	Terre Haute	The Union Hospital	*1	5	66	1,295,000	600,000	
2	Do	St. Anthonys	1	5	30	938,753	387,130	
3	Tipton	County Memorial and Operating Facilities	*1	1	52	774,448	254,922	
3	Do	Tipton County Memorial	1	1		38,460	3,594	
3	Union City	Union City Memorial	1	1	24	352,884	117,628	
3	Vincennes	Good Samaritan	1	1	40	835,040	275,539	
2	Winchester	Randolph County	*1	2	16	439,008	176,131	
3	Do	do	1	5	38	491,331	169,886	
		IOWA						
2	Audubon	Audubon County Memorial	1	1	30	485,649	161,883	
3	Bloomfield	Davis County	1	1	34	507,325	166,647	
2	Britt	Hancock County Memorial	1	1	32	503,841	165,880	
2	Cedar Rapids	St. Lukes Methodist	*1	5	169	2,494,584	817,600	
3	Cherokee	Sioux Valley	1	5	42	443,244	147,748	
2	Clarion	Community Memorial	1	1	28	287,010	93,946	
3	Corning	Rosary	1	5	38	642,051	188,350	
1	Corydon	Wayne County	1	1	34	436,370	142,707	
2	Council Bluffs	Jennie Edmundson Memorial	1	5	56	462,393	151,645	
2	Do	St. Bernards	3	2	120	1,329,850	343,283	

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	IOWA—continued						
2	Davenport	Mercy	*1	5	150	$2,532,202	$600,003
3	Do	St. Lukes	1	5	80	1,616,229	538,740
3	Denison	Crawford County Memorial	1	1	50	562,446	182,171
2	Des Moines	Iowa Methodist	1	5	27	1,864,502	96,905
3	Dewitt	DeWitt Community	1	1	32	423,238	140,000
3	Fairfield	Jefferson County	1	5	26	573,120	191,040
2	Fort Madison	Sacred Heart	*1	2	61	1,513,347	504,068
3	Greenfield	Adair County Memorial	1	1	32	390,382	126,762
3	Grundy Center	Grundy County Memorial	1	1	29	470,858	155,669
2	Guthrie Center	Guthrie County	1	1	30	391,143	129,559
2	Harlan	Myrtue Memorial	1	1	40	1,010,706	331,155
2	Jefferson	Greene County	1	5	21	487,145	160,212
3	Keosauqua	Van Buren County Memorial	1	1	20	284,812	91,995
3	Manchester	Delaware County Memorial	1	1	35	402,960	124,025
3	Maquoketa	Jackson County Public	1	1	38	530,352	176,784
3	Mount Ayr	Ringgold County	1	1	22	346,161	114,355
2	Muscatine	Muscatine County	1	1	100	1,814,617	564,618
2	Oelwein	Mercy	*1	3	32	760,407	252,900
2	Osage	Mitchell County Memorial	1	1	33	453,250	150,250
2	Osceola	Clarke County	1	1	30	518,055	170,852
3	Ottumwa	Ottumwa General	1	1	93	1,829,280	601,426
1	Perry	Dallas County	1	1	38	659,000	216,667
3	Red Oak	Murphy Memorial	1	2	18	191,258	63,258
3	Sac City	Loring	1	1	34	306,529	99,843
3	Sheldon	Community Memorial	1	1	24	339,137	111,481
2	Shenandoah	Hand Community	*1	5	24	501,000	167,000
2	Sigourney	Keokuk County	1	1	36	668,665	222,888
3	Sioux Center	Sioux Center Community	1	1	27	292,650	95,950
2	Spencer	Spencer Municipal	1	1	47	748,090	244,863
3	Storm Lake	Buena Vista County	1	1	50	533,156	172,719
2	Vinton	Virginia Gay	1	1	36	387,241	125,747
3	Waukon	Veterans Memorial	1	1	24	279,658	91,931
2	Webster City	Hamilton County Public	1	5	32	863,090	254,363
3	Westunion	Palmer Memorial	1	1	20	242,236	80,233
3	Winterset	Madison County Memorial	1	1	39	535,722	176,354
	KANSAS						
1	Burlington	Coffey County	1	1	21	316,758	125,483
3	Coffeyville	Coffeyville Municipal	1	1	74	819,625	187,608
3	Coldwater	Comanche County	1	1	18	239,515	79,345
2	Columbus	Maude Norton Memorial	*1	6	22	191,702	63,901
2	El Dorado	Susan B. Allen Memorial	*7	5	41	707,100	282,840
1	Fort Scott	Mercy	*1	1	166	2,000,000	800,000
3	Fredonia	St. Margarets Mercy	1	1	42	621,503	207,168
2	Garnett	Anderson County	1	1	32	343,162	109,887
3	Goodland	Boothroy Memorial Hospital Association	*1	5	30	155,367	48,122

2	Garnett	Anderson County	1	1	32	745, 102	62, 092
3	Goodland	Boothroy Memorial Hospital Association	*1	5	30	153, 367	48, 122
3	Greensburg	Kiowa County Memorial	*1	1	20	188, 676	62, 092
2	Iola	Allen County Hospital	1	1	40	618, 889	247, 556
2	Kansas City	University of Kansas Medical Center	1	2	76	1, 815, 058	321, 240
2	Kingman	Kingman Memorial	1	5	7	70, 374	28, 150
3	Kinsley	Edwards County	1	1	22	250, 070	83, 357
2	La Crosse	Rush County	1	1	26	269, 365	89, 788
2	Larned	St. Joseph Memorial	*1	1	43	741, 000	247, 000
2	Manhattan	Riley County	1	1	95	1, 450, 000	500, 000
2	Marion	Marion Community	1	1	25	348, 894	132, 134
3	Medicine Lodge	Medicine Lodge Memorial	*1	1	21	284, 580	69, 860
3	Norton	Norton County	1	1	34	370, 492	123, 497
3	Oberlin	Decatur County	1	1	20	267, 179	80, 727
2	Ottawa	Ransom Memorial	1	5	48	400, 000	160, 000
2	Phillipsburg	Phillips County Community	1	1	24	231, 116	90, 446
2	Pittsburg	Mt. Carmel	*1	5	44	690, 198	230, 066
2	Do	do	*1	5	10	450, 293	179, 230
2	Pratt	Pratt County	1	1	48	871, 993	278, 741
3	Quinter	Gove County Hospital and Clinic	7	6	20	200, 976	66, 992
2	Smith Center	Smith County Memorial	1	1	20	352, 402	140, 961
2	Topeka	St. Francis	1	5	33	500, 000	200, 000
2	Do	Stormont Hospital Nurses Training School	1	5	29	188, 351	75, 068
2	Do	Stormont-Vail	1	5	183	3, 326, 090	1, 330, 436
2	Do	Menninger Foundation	*3	2	64	1, 536, 772	456, 995
		KENTUCKY					
2	Albany	Clinton County	1	1	20	319, 480	212, 987
2	Ashland	Kings Daughters	1	5	96	876, 951	551, 299
2	Do	Boyd County Health Center	5	1		154, 764	103, 176
3	Do	State Tuberculosis Sanatorium	*2	1		187, 975	62, 659
2	Barbourville	Barbourville-Knox County Health Center	5	1		67, 800	45, 200
3	Bardstown	Flaget Memorial	1	1	33	405, 867	135, 289
2	Beattyville	Lee County Health Center	5	1		33, 000	22, 000
2	Bellefonte	Bellefonte	1	1	89	1, 527, 276	848, 487
2	Booneville	Owsley County Health Center	5	1		21, 000	14, 000
2	Bowling Green	Bowling Green-Warren County	*1	2	47	1, 078, 003	718, 668
2	Do	do	1	3		300, 000	150, 000
2	Do	do	5	1		61, 800	41, 200
2	Cadiz	Trigg County Hospital, Inc	1	1	20	352, 650	235, 100
3	Carlisle	Nicholas County	7	1	28	272, 240	90, 747
3	Clinton	Clinton and Hickman County	1	1	22	302, 597	99, 865
2	Corbin	Corbin Municipal Hospital	1	1	52	885, 613	590, 409
3	Covington	St. Elizabeth's	*1	5	117	1, 470, 280	490, 094
3	Do	William Booth Memorial	1	5	35	314, 394	104, 797
3	Do	Covington-Kenton County TB	2	1	64	704, 528	234, 843
2	Cynthiana	Harrison Memorial	*1	2	27	227, 924	75, 975
2	Do	Cynthiana-Harrison County Hospital	5	1		67, 500	45, 000
2	Danville	Ephraim McDowell Memorial	*1	5	24	501, 486	278, 603
2	Do	Boyle County Health Center	5	1		73, 800	49, 200
2	Dixon	Webster County Health Center	5	1		44, 574	29, 716
2	Elizabethtown	Hardin County	1	1	83	1, 059, 288	588, 493
2	Flemingsburg	Fleming County Health Center	5	1		62, 740	41, 827
2	Fort Thomas	Campbell County General	1	1	124	2, 446, 952	1, 359, 417
2	Frenchburg	Menifee County Health Center	5	1		26, 709	17, 806

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	KENTUCKY—continued						
2	Georgetown	John Graves Ford Memorial	*1	2	31	$607,500	$337,500
2	Do	Scott County Health Center	5	1		66,454	44,179
2	Glasgow	T. J. Samson Community	*1	5	71	603,131	402,088
2	Do	Barren County Health Center	5	1		69,290	46,193
3	Do	State TB Sanatorium	*2	1		198,839	66,280
2	Harlan	Harlan County Health Center	5	1		92,000	61,133
2	Hopkinsville	Western State	3	4	320	1,046,594	697,730
3	Do	Jennie Stuart Memorial	*1	2	22	201,583	64,527
2	La Grange	Oldham County Health Center	5	1		49,596	33,064
2	Lakeland	Central State	3	8	269	1,446,582	964,388
3	Lancaster	Garrard County	1	1	30	306,129	99,626
2	Lebanon	Mary Immaculate Infirmary	1	1	46	707,670	471,780
3	Leitchfield	Grayson County War Memorial	7	1	17	233,623	76,374
1	Lexingdon	Eastern State	3	8	300	1,219,120	812,747
2	Do	Good Samaritan Hospital	1	5	50	900,000	500,000
3	Liberty	Casey County War Memorial	7	1	21	228,839	74,780
2	London	Laurel County Health Center	5	1		63,000	42,000
3	Do	State TB Sanatorium	*2	1		195,705	65,235
2	Louisville	Red Cross Association	*1	5	36	651,872	424,081
2	Do	Jewish Hospital	1	1	118	2,649,474	1,284,066
2	Do	Chronic Disease Hospital	4	1	173	572,705	374,002
2	Do	State Department Health Laboratory	8	5		485,500	323,667
3	Do	John N. Norton Memorial Infirmary	*1	5	124	901,146	300,381
3	Do	Children's Hospital	1	5	125	1,656,794	1,104,529
3	Do	Louisville General	*1	5		201,783	67,261
3	Do	Our Lady of Peace	3	1	108	2,209,146	732,466
3	Madisonville	State TB Sanatorium	*2	1		198,556	66,186
2	Mayfield	Mayfield-Graves County Health Center	5	1		60,000	40,000
2	Maysville	Hayswood Hospital	*1	5	32	555,000	370,000
2	Do	Mason County Health Center	5	1		73,875	49,250
1	Murray	Murray-Calloway County Health Center	5	1		60,000	40,000
2	Owensboro	Owensboro-Daviess County Health Center	5	1		96,630	64,420
3	Do	Owensboro-Daviess County	1	5	48	1,130,000	376,666
3	Owenton	Owen County Memorial	1	1	21	250,193	166,796
2	Paducah	Riverside Hospital	*1	2	50	918,584	510,324
2	Paris	Bourson County	1	1	91	1,159,370	362,132
3	Do	State TB Sanatorium	*2	1		199,300	66,433
2	Pikeville	Pike County Health Center	5	1		144,000	96,000
2	Pinevil'e	Bell County Health Center	5	1		63,030	42,020
3	Princeton	Caldwell War Memorial	1	1	35	402,555	134,185
2	Russellville	Logan County Health Center	5	1		20,770	13,847
3	Do	Logan County	1	1	52	542,097	180,699
2	Scottsville	Allen County War Memorial	1	1	31	450,130	300,087
2	Shelbyville	Kings Daughters	1	1	60	1,069,875	594,374
2	Somerset	Pulaski County Health Center	5	1		102,000	68,000

2	Somerset	Pulaski County Health Center	5	1		102,000	68,000
2	Tompkinsville	Monroe County War Memorial	1	1	20	304,300	196,200
2	Waverly Hills	Waverly Hills TB Sanatorium	*2	3		135,000	90,000
2	Williamsburg	Whitley County Health Center	5	1		75,000	50,000
	LOUISIANA						
2	Alexandria	Alexandria-Rapides Health Unit	*5	1		282,556	180,836
3	Do	St. Francis Cabrini	1	1		279,582	93,194
2	Amite	Tangipahoa Parish Health Center	5	1		108,374	47,099
2	Bastrop	Morehouse Parish Health Center	5	1		68,245	33,774
3	Baton Rouge	Baton Rouge General	1	1	275	2,134,623	689,875
3	Bogalusa	Wash-St. Tammany Charity	*1	4	70	823,077	274,359
3	Coushatta	Red River Parish Public Health Center	5	1		113,188	22,072
2	Covington	St. Tammany Parish Health Center	5	1		43,740	28,431
1	Do	St. Tammany Parish	1	1	30	365,625	234,000
3	Deridder	Beauregard Memorial Baptist	1	1		196,368	42,944
3	East Baton Rouge	Parish Health Unit	*5	3		62,639	16,471
3	Do	do	5	1		137,069	45,689
2	Franklin	St. Mary Parish Hospital	1	1	25	414,750	215,000
2	Greenwell Springs	Greenwell Springs TB	2	5	80	654,334	418,774
3	Homer	Homer Memorial	1	1	25	263,807	86,396
2	Houma	Terre Bonne	1	1	100	1,528,290	812,500
3	Do	Terrebonne Parish Health Center	5	1		103,207	48,815
2	Jena	LaSalle Parish Health Unit	5	1		36,926	22,425
2	Jennings	Jeff Davis Parish Public Health Center	5	1		53,080	34,502
2	Kentwood	Tangipahoa Parish Health Center	6	1		24,870	9,776
3	Lafayette	Our Lady of Lourdes	1	1	50	560,548	150,732
3	Do	Lafayette Charity TB Ward	1	2	100	1,064,163	211,893
2	Lake Charles	Calcasieu-Lake Charles Health Unit	5	1		258,440	167,986
3	Do	St. Patricks	1	2		70,463	23,487
2	Do	Lake Charles Memorial	1	1	100	1,794,561	1,116,512
1	Lake Providence	Lake Providence	1	1	42	426,562	273,000
1	Lutcher	St. James	1	1	25	304,688	195,000
2	Mandeville	Southeast Louisiana State	3	1	400	5,171,354	2,953,736
2	Marksville	Avoyelles Parish Public Health Center	5	1		51,812	31,863
3	Minden	Webster Parish Health Unit	5	1		58,176	19,392
1	Monroe	St. Francis Sanatorium	*1	2	167	2,543,940	487,500
1	Morgan City	Morgan City General	1	1	36	495,000	309,120
3	Natchitoches	Natchitoches Parish Health Unit	5	1		76,164	25,388
2	New Orleans	Charity Hospital of Louisiana	*1	2		488,099	313,342
2	Do	Alton Ochsner Medical Foundation	1	1	250	5,307,269	1,325,000
2	Do	Orleans Parish Health Center	5	1		55,396	35,382
2	Do	do	5	1		60,938	39,000
3	Do	Touro Infirmary	1	2	102	2,503,829	729,030
3	Do	Charity Hospital of Louisiana	1	5	153	510,800	207,500
3	Do	DePaul Sanatorium	3	1	100	1,256,419	418,806
3	Do	Soraparu Park Public Health Center	5	1		55,811	36,277
1	Do	Crippled Children's	4	1	50	1,032,874	315,000
3	Newellton	Legion Memorial	1	1		49,909	16,636
3	Opelousas	St. Landry Parish Public Health Center	5	1		100,926	61,884
2	Pineville	Central Louisiana State	3	2		135,048	65,000
3	Do	do	3	2		25,846	5,718
2	Ponchatoula	Tangipahoa Health Center	6	1		25,594	11,700
2	Rayville	Richland Parish Health Center	5	1		59,726	33,448

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	LOUISANA—continued						
3	Ruston	Ruston	*1	2	7	$59,874	$19,958
3	Do	do	*1	2		11,077	3,692
2	Shreveport	Confederate Memorial Medical Center	1	1	128	8,100,327	533,155
2	Do	Confederate Memorial Nurses' School	1	4		1,390,095	889,661
3	Springhill	Webster Parish Health Unit	5	1		52,553	17,518
2	Sulphur	West Calcasieu Camfron	1	1	50	665,797	413,150
3	Tallulah	Madison Parish Health Center	5	1		58,303	19,434
2	Thibodaux	St. Joseph	1	1	42	474,571	286,064
2	Do	Lafourche Parish Public Health Center	5	1		79,593	51,736
2	Ville Platte	Evangeline Parish Public Health Center	5	1		53,791	30,784
3	Winnfield	Winn Parish Health Center	5	1		52,985	17,662
	MAINE						
3	Augusta	Augusta General	*1	5	48	343,901	114,634
3	Do	Augusta State	3	2		440,858	115,595
3	Bangor	Chronic Disease	4	7	31	180,950	45,755
2	Biddiford	Webber	*1	5	39	896,964	493,331
3	Fort Fairfield	Community General	*1	5	36	485,811	267,196
2	Fort Kent	Peoples Benevolent	*1	1	60	1,207,778	664,278
3	Lewiston	Central Maine General	*1	5	37	678,659	226,220
1	Millinocket	Millinocket Community	1	1	25	635,000	349,250
2	Portland	Mercy	*1	2	82	1,450,927	798,009
3	Do	Portland City	4	2	16	94,325	51,879
2	Waterville	Thayer Hospital	*1	1	63	1,139,510	626,731
	MARYLAND						
1	Annapolis	Annapolis Emergency	*1	2	90	1,293,600	431,200
3	Do	Anne Arundel General	*1	2		179,019	78,768
3	Do	Anne Arundel County Bldg	5	1		418,528	158,528
1	Baltimore	Provident	*1	2	12	191,990	52,313
2	Do	University of Maryland Psychiatric Unit	*1	2	73	3,570,762	523,144
2	Do	TB Unit, Baltimore City	1	2	294	2,773,144	523,144
2	Do	Franklin Square Hospital	*1	2		146,895	48,965
2	Do	Mount Pleasant Sanatorium	2	1	60	1,321,151	447,433
2	Do	Southeast Health District Bldg	5	8		356,512	10,000
2	Do	Southern Health Department	5	1		661,000	20,167
3	Do	State Bacteriology Laboratory	*8	5		100,440	33,056
3	Do	Health and Welfare Center	5	1		189,000	50,222
1	Bel Air	Kent and Queen Annes Home	1	5	28	171,026	57,008
3	Chestertown	Prince Georges General	1	2	128	1,264,298	413,650
3	Cheverly	Cumberland Memorial	1	2	8	159,349	70,113
3	Cumberland	Caroline County Health Center	5			61,920	27,245
2	Denton	Memorial Hospital	1	5	86	1,500,000	500,000
1	Easton	Frederick Memorial	*1	5	44	798,959	351,542
3	Frederick	Washington County	*1	5	139	1,836,762	435,150
2	Hagerstown						

2	Hagerstown	Frederick Memorial	*1	5	44	798, 959	351, 542
		Washington County	*1	5	139	1, 836, 762	435, 150
3	Havre de Grace	Havre de Grace Public Health Center	6	1		58, 124	25, 574
2	Leonardtown	St. Marys County Building	5	1		140, 632	38, 343
3	Oakland	Garrett County Memorial	7	1	34	533, 183	177, 728
2	Prince Frederick	Calvert County Hospital	1	1	29	772, 629	300, 162
3	Rockville	Christ Child Convalescent	4	1	54	439, 905	171, 778
2	Salisbury	The Peninsula General	*1	5	63	1, 103, 450	485, 518
2	Westminster	Carroll County War Memorial	5	1		164, 072	72, 192
	MASSACHUSETTS						
3	Arlington	Symmes-Arlington	*1	3		279, 938	114, 775
3	Athol	Athol Memorial	1	1	48	779, 454	259, 818
2	Ayer	Community Memorial	*1	5	18	288, 727	120, 824
1	Boston	Boston City Hospital	*1	5		150, 000	63, 000
2	Do	New England Deaconess	*1	5	76	3, 574, 036	409, 018
2	Do	Carney Hospital	1	1		5, 316, 752	250, 000
2	Do	The Childrens Hospital	*1	2		234, 982	43, 114
2	Do	Peter Bent Brigham	1	5		171, 483	70, 308
3	Do	The Childrens Hospital	1	5	64	703, 858	231, 886
3	Do	Massachusetts Eye and Ear Infirmary	1	5		818, 374	272, 791
3	Do	Beth Israel	*1	2		838, 080	275, 000
3	Do	Boston Lying-in	*1	3		78, 788	32, 303
3	Do	Peter Bent Brigham	1	5	34	285, 858	95, 286
2	Brighton	St. Elizabeth	1	5		1, 001, 559	116, 635
3	Brockton	Brockton	*1	5	41	989, 042	425, 288
2	Brookline	Brookline Public Health Center	5	1		558, 390	189, 853
3	Clinton	Clinton	1	4	77	661, 184	220, 395
3	Concord	Emerson	*1	5	60	723, 702	301, 384
2	Framingham	Framingham Union	*1	5	94	1, 319, 737	250, 000
2	Greenfield	Franklin County Public	*1	5	102	998, 756	399, 502
2	Gruton	Community	1	1	41	575, 584	184, 884
2	Holden	Holden District	1	5	31	553, 315	240, 436
1	Holyoke	Holyoke City Hospital	4	1	150	900, 000	250, 000
2	Do	Holyoke Hospital	*1	5	151	1, 641, 717	400, 160
3	Hyannis	Cape Cod	*1	5	30	1, 109, 928	151, 666
1	Jamaica Plain	Hyams Laboratory	8	2		248, 000	104, 509
2	Lowell	St. Josephs Hospital	1	2	39	905, 086	250, 000
2	Do	Lowell General	*1	2	74	1, 597, 119	250, 000
2	Lynn	Union	*1	1	75	1, 306, 870	250, 000
2	Malden	Malden Hospital	*1	2	30	810, 078	250, 000
2	Marlborough	Marlborough	*1	5	24	965, 000	424, 600
2	Medford	Lawrence Memorial and NH	*1	5	69	847, 360	364, 365
3	Methuen	Bon Secours	*1	1		2, 506, 659	276, 637
3	Milton	Milton Hospital and Convalescent Home	*1	1	53	1, 015, 563	264, 419
2	Natick	Leonard Morse Hospital	*1	5	73	766, 631	250, 000
3	Needham	Glover Memorial	*1	5	53	922, 261	306, 587
2	New Bedford	St. Lukes	*1	5	107	1, 766, 783	500, 000
1	Newburyport	Anna Jaques	*1	5	59	696, 880	313, 596
2	Norwood	Norwood Hospital	*1	5	50	398, 373	127, 294
2	Palmer	Wing Memorial	1	1	42	830, 367	373, 665
2	Pocasset	Barnstable County Sanitarium	2	2	36	766, 162	229, 832
3	Quincy	Quincy Health Center	5	1		521, 373	173, 791
1	Roxbury	Jewish Memorial	*4	5	50	528, 500	216, 685

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	MASSACHUSETTS—continued						
2	Springfield	Wesson Maternity	1	1	81	$1,853,399	$250,000
2	Do	Springfield Municipal	4	1	237	6,320,000	250,000
2	Stoneham	New England Sanitarium	1	2	100	903,080	347,637
3	Ware	Mary Lane	*1	5	20	448,478	112,195
2	Winchester	Winchester	*1	5	42	907,587	353,959
2	Woburn	Charles Choate Memorial	*1	5	34	414,250	161,557
	MICHIGAN						
2	Albion	James W. Sheldon Memorial	*1	5	30	492,034	171,418
3	Benton Harbor	Mercy	*1	5	87	1,591,776	482,945
1	Charlevoix	Charlevoix	1	1	44	612,500	329,175
1	Charlotte	Hayes-Green-Beach	*1	2	40	660,700	322,850
2	Dearborn	Oakwood	7	1	200	5,420,000	1,442,300
1	Detroit	St. Clair	3	1	225	3,461,000	800,000
2	Dowagiac	Lee Memorial	1	1	62	1,180,150	520,000
3	Flint	McLaren General	1	1	151	2,741,403	902,801
3	Frankfort	Paul Oliver Memorial	1	1	29	498,425	269,776
1	Fremont	Gerber Memorial	*1	5	44	605,000	300,000
2	Gaylord	North Michigan Tuberculosis Sanitarium	*2	5	50	530,000	238,500
3	Do	Otsego County Memorial	1	1	32	314,923	147,071
2	Grand Haven	Grand Haven Municipal	*1	5	17	397,990	52,290
3	Grand Rapids	Mary Free Bed Guild	*1	5	13	304,900	137,205
3	Greenville	United Memorial	7	1	70	1,116,053	557,950
3	Hancock	St. Josephs	*1	1	160	2,499,990	833,330
3	Hancock	Tuberculosis Sanatorium	2	1	100	987,000	329,494
2	Hart	Oceana Hospital	1	1	32	450,500	238,975
3	Hastings	Pennock	1	5	22	488,231	162,477
3	Holland	Holland City	*1	5	24	329,265	94,956
2	Ionia	Ionia County Memorial	1	1	50	821,970	431,534
3	Iron Mountain	Dickinson County Memorial	1	1	48	926,953	463,476
3	Kalamazoo	Kalamazoo State	3	2	128	576,076	256,984
2	Kalkaska	Kalkaska County Health Center	7	1	10	179,100	99,960
3	L'Anse	Baraga County Memorial	1	1	32	618,000	352,800
2	Lapeer	Lapeer County	*1	1	52	946,812	400,616
3	Manistee	Mercy	1	2	56	784,800	261,600
3	Manistique	Schoolcraft Memorial	1	1	32	392,121	130,707
3	Marlette	Marlette Community	1	1	22	290,229	138,430
2	Marshall	Oaklawn	*1	1	47	687,600	338,800
3	Menominee	Marshall B. Lloyd Clinic	1	2	72	846,369	282,123
3	Do	St. Joseph	*1	5		203,440	90,000
2	Muskegon	Mercy	*1	2	68	1,836,072	700,204
1	Paw Paw	The Lake View Community	1	1	41	453,000	249,150
2	Port Huron	Port Huron Hospital	1	2	51	651,872	222,500
3	Rogers City	Rogers City	1	1	27	458,390	152,797
3	Saginaw	St. Luke's	*1	1	141	2,107,278	702,426

3	Rogers City	Rogers City	1	1	27	458,390	152,797
3	Saginaw	St. Luke's	*1	1	141	2,107,278	702,426
3	Sault Ste. Marie	Chippewa County War Memorial	*1	2		80,440	44,242
3	South Haven	South Haven	1	5	31	222,413	101,090
3	St. Joseph	St. Joseph's	*1	1	104	1,901,316	633,772
3	Sturgis	Sturgis Memorial	*1	2	28	541,959	180,653
2	Tawas City	Tawas	1	1	36	652,600	358,930
3	Three Rivers	Three Rivers	*1	5	31	469,404	234,702
2	Traverse City	James Decker Munson	*1	5	64	1,240,508	599,500
1	Trenton	Riverside Osteopathic	*1	2	36	620,000	234,000
1	West Branch	Tolfree Memorial	*1	5	12	309,000	178,200
3	Yale	Yale Community Hospital	1	1	26	345,800	180,290
	MINNESOTA						
1	Aitkin	Aitkin Community	1	1	30	400,000	180,000
3	Anoka	Anoka State	3	2	60	1,233,312	553,190
3	Appleton	Appleton Municipal	1	4	20	429,606	185,403
3	Bagley	Clearwater County Memorial	1	1	30	331,160	110,387
3	Baudette	Baudette Municipal	1	1	24	333,279	110,225
3	Benson	Swift County-Benson	1	1		371,611	37,973
3	Blue Earth	Community Memorial	1	1	32	454,695	151,565
2	Brainerd	St. Josephs	1	1	129	2,069,515	925,565
3	Breckenridge	St. Francis and and Nursing Home	*1	1	123	2,162,143	971,254
3	Buffalo	Buffalo Memorial	1	1	28	358,696	160,518
2	Crookston	Bethesda	1	1	62	1,028,056	460,813
3	Do	St. Francis	1	1		1,865,793	79,282
3	Duluth	St. Lukes Hospital	1	5		2,435,000	15,750
3	Do	St. Lukes Infirmary	4	1	150	1,161,961	387,320
2	Glenwood	Glenwood Community	*1	5	19	290,909	130,909
3	Greenbush	Greenbush Community	1	1	20	250,585	74,948
2	Hastings	Salve Regina	*1	1	50	1,002,040	450,918
3	Litchfield	Meeker County	1	1	62	870,290	391,630
2	Madison	Madison	1	1	30	561,661	251,249
2	Minneapolis	Mayo Memorial Medical Center	1	5	175	11,677,596	2,000,000
3	Do	Variety Club Heart	4	1	78	1,400,507	381,672
3	Do	University of Minnesota Health Service	5	1		905,816	295,853
3	Morris	Stevens County Memorial	1	1	40	544,650	245,092
3	New Prague	Community Memorial	1	1	32	429,472	193,262
3	Olivia	The Renville County	1	1	41	399,920	133,306
3	Ortonville	Ortonville Municipal	1	1	30	377,335	169,801
3	Pelican Rapids	Pelican Valley Health Center	1	1	23	267,001	120,150
3	Red Lake Falls	St. John's	1	1	20	414,081	186,337
3	Redwood Falls	Redwood Falls	1	4	40	537,446	241,851
3	Rochester	Rochester Public Health Center	5	1		274,714	91,439
3	Sauk Centre	St. Michael's	1	1	50	760,971	233,657
2	Shakopee	St. Francis	1	1	50	816,596	366,596
3	Slayton	Murray County Memorial	1	1	40	469,347	150,745
2	St. Cloud	St. Cloud Hospital	*1	5	44	636,148	286,266
2	St. Paul	Charles T. Miller	*1	5	54	540,987	243,444
2	Do	St. John's	1	2	59	1,707,457	330,393
1	Thief River Falls	Northwestern	*1	5	64	942,703	419,717
3	Wells	Village of Wells Hospital	1	1	32	331,751	110,583
3	Wheaton	Wheaton Community	1	1	22	254,300	84,767
3	Worthington	Worthington Municipal	1	1	50	695,328	231,776
3	Do	do	*1	2	27	326,347	146,526

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	MISSISSIPPI						
3	Aberdeen	Monroe County Public Health Center	5	1		$56,326	$37,551
2	Ackerman	Choctaw County Community	1	1	25	286,200	187,266
3	Amory	Monroe County Branch Health Center	6	1		33,391	22,260
3	Ashland	Ashland Clinic	7	1	6	122,456	86,874
3	Belzoni	Humphreys County Memorial	1	1	40	335,000	108,250
3	Booneville	Northeast Mississippi	*1	1	50	600,973	195,638
3	Brandon	Rankin County Public Health Center	5	1		31,009	10,303
3	Canton	Kings Daughters	1	3	29	422,465	281,510
3	Carrollton	Carroll County Public Health Center	5	1		6,000	4,000
3	Do	do	7	1	3	52,893	17,631
3	Carthage	Leake County Memorial	*1	1	50	528,520	166,640
3	Centreville	Field Memorial	1	1	50	507,201	331,334
3	Clarksdale	Coahoma County Hospital	*1	1	100	1,301,094	809,870
3	Cleveland	Bolivar County Public Health Center	5	1		102,531	32,594
3	Collins	Covington County	1	1	25	220,882	144,338
3	Columbia	Marion County General Hospital	*1	1	80	847,974	280,751
3	Columbus	Lowndes County Health Center	5	1		87,299	58,199
3	Corinth	Alcorn County Health Center	5	1		85,451	27,641
2	De Kalb	Kemper County Hospital	*1	2		62,135	41,423
3	Do	do	1	1	25	228,611	74,695
3	Durant	District 2 Community	1	1	25	253,924	82,878
3	Do	Holmes County Auxiliary Health Center	6	1		12,639	8,426
3	Ellisville	Ellisville Municipal Clinic	7	1	8	81,884	26,747
3	Forest	Southeast Lackey Memorial	*1	1	47	414,890	132,896
3	Do	Scott County Public Health Center	5	1		65,125	43,416
3	Gloster	Gloster Clinic	7	1	4	50,029	14,843
2	Greenville	Washington County	1	1	200	2,105,114	1,387,400
3	Do	Washington County Public Health Center	5	1		122,802	40,892
3	Greenwood	Greenwood Leflore	1	4	135	1,771,340	1,157,560
3	Do	Leflore County Health Center	5	1		148,027	43,287
2	Gulfport	Memorial Hospital	1	1	112	1,472,001	743,067
3	Hattiesburg	Forrest County	*1	1	100	1,303,781	859,954
3	Hazelhurst	Hardy Wilson Memorial	1	1	50	692,941	227,585
3	Hickory Flat	Hickory Clinic	6	1		31,793	21,196
3	Holly Springs	Marshall County Health Center	5	1		56,679	37,786
2	Indianola	South Sunflower County	1	1	52	464,490	287,075
3	Do	Sunflower County Health Center	5	1		67,400	22,467
3	Inverness	Sunflower County Branch Health Center	6	1		14,077	9,385
2	Jackson	University Teaching Hospital	1	1	350	5,000,000	3,000,000
3	Kosciusko	Attala County Public Health Center	5	1		53,560	17,853
3	Laurel	Jones County	*1	1	105	1,203,925	775,950
3	Leakesville	Greene County	1	1	25	235,619	77,990
3	Lexington	Holmes County Community	1	2	16	216,487	144,228
3	Do	Holmes County Health Center	5	1		46,266	15,422
3	Louisville	Winston County Public Health Center	5	1		61,628	20,543
3	Lucedale	George County	1	1	30	272,217	88,105

3	Lucedale	George County	1	1	30	272,217	88,105
3	Macon	Noxubee County Community	*1	1	40	622,943	406,962
3	Meadville	Franklin County Memorial Hospital	1	1	30	269,537	87,790
3	Do	Franklin County Public Health Center	5	1		43,286	14,379
3	Meridian	East Mississippi Mental	3	1	260	1,588,152	1,058,768
3	Nettleton	Nettleton Public Health Center and Clinic	5	1		46,873	30,915
2	Newton	Newton County	1	4	40	647,390	417,260
3	Okolona	Okolona	1	1	25	247,520	162,580
3	Philadelphia	Neshoba County Health Center	5	1		58,402	19,467
2	Pontotoc	Community	1	1	30	401,852	242,968
3	Do	Pontotoc County Health Center	5	1		41,270	27,513
3	Port Gibson	Claiborne County	1	1	25	245,000	160,500
3	Prentiss	Jefferson Davis County	*1	1	26	223,730	72,843
3	Purvis	Lamar County Public Health Center	5	1		48,123	16,041
3	Ripley	Tippah County Hospital	*1	1	40	448,307	145,229
3	Rolling Fork	Sharkey Issaquena Community	1	1	22	192,111	62,120
3	Do	Sharkey-Issaquena County	5	1		46,117	15,352
3	Ruleville	North Sunflower County	1	1	31	417,287	137,929
3	Sanatorium	Tuberculosis Infirmary for Negroes	2	5	154	1,753,115	584,372
3	Starkville	Felix Long Memorial	1	1	40	415,106	128,463
3	Do	Oktibbeha County Health Center	5	1		58,763	19,588
3	Tunica	Tunica County	1	1	25	228,027	73,406
3	Tupelo	North Mississippi Community	1	5	48	297,674	197,522
3	Vaiden	Carroll County Branch Public Health Center	6	1		44,257	29,505
1	Vicksburg	Mercy Hospital—Street Memorial	1	1	200	2,788,211	750,000
1	Do	Lutheran Hospital	*1	5	180	2,008,360	750,000
3	West Enterprise	Clarke County Branch Public Health Center	6	1		10,822	7,215
3	Waynesboro	Wayne County	1	1	25	213,618	139,506
2	West Point	Ivy Memorial	1	1	50	740,585	469,057
3	Do	Clay County Public Health Center	5	1		69,410	22,657
3	Wiggins	Stone County	1	1	20	174,628	112,615
		MISSOURI					
2	Chillicothe	Chillicothe	*1	2	20	419,588	209,794
3	Hayti	Pemiscot County Memorial	1	1	56	541,552	178,062
2	Independence	Independence Sanitarium Hospital	*1	2	30	529,887	264,944
2	Kansas City	St. Lukes	*1	5	120	2,451,373	1,153,798
2	Do	Kansas City General	1	2	82	1,037,521	518,760
3	Do	Menorah	*1	2	132	2,558,044	482,697
3	Kennett	Dunklin County	1	1	65	947,194	314,731
3	Kirksville	College of Osteopathy and Surgery	*1	5	100	1,055,989	351,996
2	Louisiana	Pike County	1	2	22	435,421	217,710
2	Milan	Sullivan County Memorial Hospital	1	1	52	562,797	280,875
2	Monett	St. Vincents Hospital	1	2	45	823,629	401,814
2	Mount Vernon	Missouri State Sanitarium and Training School	*2	5	69	360,000	180,000
3	Nevada	Nevada City	*1	5	34	440,000	146,667
3	Perryville	Perry County Memorial	1	1	50	624,791	204,595
2	Poplar Bluff	Butler County Public Health Center	5	1		91,050	30,350
3	Rolla	Phelps County Public Memorial	1	1	58	701,876	223,575
2	Springfield	Burge	*1	5	120	871,315	435,658
2	Do	City	1	1	51	310,000	155,000
3	Do	St. Johns	*1	1	265	7,357,826	3,639,028

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	MISSOURI—continued						
2	St. Louis	Depaul					
2	Do	St. Louis Children's	*1	5	85	$2,766,900	$1,383,450
2	Do	Renard-Washington University	*1	2	60	2,957,962	813,440
3	Do	St. Louis health centers	3	1	100	1,432,398	716,199
2	Troy	Lincoln County Memorial	5	1		905,000	300,256
			1	1	50	628,353	314,176
	MONTANA						
2	Baker	Fallon County	1	1	19	299,416	119,646
3	Big Timber	Sweet Grass County	1	1	10	162,851	54,284
3	Choteau	Teton Memorial	1	1	25	208,492	67,202
3	Circle	McCone County	1	1	10	170,462	55,414
3	Culbertson	Roosevelt Memorial	*1	1	10	99,860	36,642
3	Cut Bank	Glacier County Memorial	1	1	36	307,173	101,404
3	Harlowton	Wheatland Memorial	1	1	20	135,515	49,851
3	Hot Springs	Sanders County	1	1	19	256,500	60,000
3	Jorden	Garfield County	1	1	15	249,334	105,743
3	Libby St. Johns	Lutheran	*1	1	26	84,529	30,903
2	Livingston	Livingston Community	1	1	52	675,474	269,632
3	Malta	Malta Hospital	1	1	30	265,793	112,723
2	Philipsburg	Granite County	1	1	10	235,233	92,093
2	Plentywood	Sheridan Memorial	1	1	21	196,082	50,000
3	Red Lodge	Carbon County Memorial	1	1	26	324,544	106,648
2	Roundup	Roundup Memorial	1	1	18	182,487	72,995
3	Scobey	Daniels Memorial	1	1	17	267,412	112,137
3	Shelby	Toole County	1	1	20	339,220	113,073
	NEBRASKA						
3	Albion	Boone County Community	1	1	20	169,500	56,500
2	Alma	Alma City Hospital	1	1		54,437	14,711
2	Burwell	Burwell	1	1	17	206,685	110,081
2	Callaway	Callaway Municipal Hospital	1	1	10	113,871	60,381
3	Chappell	Miller Memorial	1	1	14	161,860	41,654
2	Cozad	Cozad Municipal	1	1	20	192,265	98,992
3	Crawford	Community Memorial	1	1	12	188,990	53,771
2	Creighton	Lundberg Memorial Hospital	1	1	18	243,780	121,890
3	Crete	Crete Municipal	1	1	25	222,274	72,591
2	Franklin	Franklin County Memorial	1	1	20	227,442	121,136
2	Grand Island	St. Francis	*1	2	65	863,384	448,854
2	Grant	Perkins County Community	1	1	20	226,580	107,688
3	Hebron	Thayer County Memorial	1	1		94,754	9,899
2	Henderson	Henderson Community	*1	1		128,084	16,977
3	Kearney	St. Lukes	1	1		32,801	17,470
3	Kimball	Kimball County	1	1	25	230,445	76,415
2	Loup City	Sacred Heart Hospital	1	1	25	356,376	178,173
2	Minden	Kearney County Hospital	*1	1	25	361,489	174,370

		Kearney County Hospital	*1	1	25	361,489	174,370
3	Neligh	Antelope Memorial	1	1	30	363,948	191,291
3	Norfolk	Our Lady of Lourdes	1	1		67,174	35,777
3	Oakland	Oakland Memorial	1	1	20	247,875	82,018
2	Ogallala	Ogallala Memorial	1	1	30	445,494	234,873
1	Omaha	Psychiatric Unit, University of Nebraska	3	1	89	1,250,000	250,000
2	Do	Creighton Memorial, St. Joseph	*1	2		2,268,825	240,793
2	Oneill	St. Anthonys	1	1	36	470,028	249,764
2	Paunee City	Pawnee County Memorial	1	1	25	235,585	124,638
2	Plainview	Plainview General Hospital	1	1		78,728	8,939
2	Schuyler	Memorial Hospital	1	1	25	334,260	167,060
3	Scottsbluff	St. Mary	1	1		1,481,191	64,310
3	Seward	Seward Memorial	1	1	26	219,523	70,608
2	Spalding	St. Johns Sullivan Memorial	1	1	20	208,315	110,949
2	Syracuse	Syracuse Community Memorial	1	1	20	270,695	140,976
2	Wahoo	Saunders County Memorial	1	1	31	332,103	107,497
2	Wakefield	Wakefield Community	1	1	18	182,419	60,147
2	West Point	West Point Memorial	*1	1	75	1,181,166	238,256
	NEVADA						
3	Fallon	Churchill Public	1	1	21	229,384	6,597
2	Reno	St. Marys	1	5	48	755,521	251,840
2	Do	Washoe Medical Center	*1	5		23,277	7,759
2	Do	Nevada State	3	2	60	156,033	52,011
2	Do	Nevada State Hospital	*3	4		83,067	27,689
3	Sparks	State Mental	3	3	20	25,183	2,511
	NEW HAMPSHIRE						
3	Conway	The Memorial	1	5	17	271,019	90,340
2	Dover	Wentworth-Dover City	*1	5	42	781,148	252,000
2	Hanover	Mary Hitchcock Memorial	1	5	88	2,062,173	600,000
3	Do	do	*1	5		906,170	202,056
3	Laconia	Laconia	1	5	36	1,153,528	343,120
2	Newport	Carrie F. Wright	1	1	25	367,793	122,598
3	Peterborough	Monadnock Community	1	5	14	550,745	181,207
3	Plymouth	Sceva Speare Memorial	1	1	31	589,655	180,237
3	Wolfeboro	Huggins	*1	5	46	510,401	169,599
	NEW JERSEY						
2	Ancora	Fourth State Mental	*3	1	384	7,358,553	1,200,000
3	Camden	Our Lady of Lourdes	1	1		4,515,222	173,760
3	Cape May Courthouse	Burdette Tomlin Memorial	1	1	65	703,146	234,382
2	Cedar Grove	Overbrook	3	2	100	1,504,772	350,000
2	Elizabeth	General and Dispensary	1	2	37	877,680	231,059
2	Flemington	Hunterdon Medical Center	1	1	106	2,527,950	727,040
3	Greystone Park	State Mental	3	2	110	421,750	127,673
2	Hackensack	Hackensack Hospital	1	2	111	2,342,581	690,592
2	Long Branch	Monmouth Memorial	1	2	119	1,398,047	450,000
3	Menlo Park	Mental Diagnostic Center	3	1	65	1,285,253	403,851
2	Morristown	Memorial	1	1	236	2,680,199	815,939
2	Mount Holly	Burlington County	1	2	78	737,166	246,800
3	Neptune	Fitkin Memorial	1	2	100	1,173,756	373,277
3	Newton	Memorial	1	5	60	1,014,500	338,166
2	Paramus	Bergen Pines County	2	1	124	4,748,064	563,330

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	NEW JERSEY—continued						
2	Patterson	St. Josephs	*1	4	92	$1,302,330	$515,424
3	Do	Barnert Memorial	*1	2	19	921,481	177,769
3	Perth Amboy	General	1	5	20	441,602	176,641
3	Do	do	1	5	46	384,594	125,002
2	Plainfield	Muhlenburg	1	5	110	2,306,731	501,995
3	Point Pleasant	Point Pleasant	1	2	31	325,705	71,800
2	Princeton	Princeton	1	5	53	1,686,911	372,619
2	Do	do	*1	5		34,670	13,868
3	Red Bank	Riverview	1	2	35	768,000	300,000
3	Ridgewood	Valley	1	1	71	1,607,731	543,494
3	Salem	County Memorial	1	1	94	1,222,433	445,900
2	Secaucus	Mental Diseases, female	3	2	300	1,054,455	421,782
2	Do	Mental Diseases, male	3	2	168	1,458,192	472,000
2	Summit	Overlook	1	5	199	2,195,853	675,000
2	Trenton	St. Francis Hospital	1	2	307	4,127,985	1,320,000
	NEW MEXICO						
3	Alamogordo	Gerald Champion Memorial	1*	1	26	236,085	78,029
3	Albuquerque	South West Presbyterian Sanitorium	1	5	63	1,028,931	325,000
3	Do	Bataan Memorial Methodist	1	1	98	1,472,781	425,000
3	Carrizozo	Lincoln County Municipal	1	1	25	210,466	69,155
2	Clovis	Memorial	1	5	34	318,930	143,000
3	Farmington	San Juan County	1	1	44	507,247	275,009
3	Hobbs	Lea County Community	1	1	78	1,021,565	200,000
3	Las Cruces	Memorial General	1	1	75	792,364	250,000
2	Las Vegas	Las Vegas	1	1	46	572,898	272,000
3	Melrose	Eastern New Mexico Memorial	1	1		66,426	27,000
3	Portales	Roosevelt County	1	1	35	461,972	152,496
3	Ruidoso	Hondo Valley General	1	1	15	154,752	43,251
2	Santa Fe	St. Vincent Hospital	1	7	200	3,438,358	1,429,561
3	Santa Rosa	Guadalupe County	1	1	22	252,000	156,000
3	Tucumcari	General Maternity Wing	1	2	8	50,541	15,514
	NEW YORK						
3	Albany	Albany	1	2	128	4,246,389	1,415,463
3	Albion	Arnold Gregory Memorial	1	4	50	604,048	201,349
3	Alexandria Bay	Edward John Noble	1	1	30	437,317	145,772
3	Batavia	St. Jerome	1	7	150	1,604,059	534,686
3	Do	Genesee Memorial	1	4	119	1,588,236	529,412
3	Bay Shore	Southside	1	2	34	937,942	312,647
2	Bellrose Manor	Long Island Jewish	1	1	200	5,364,965	1,530,832
3	Brockport	Lakeside Memorial	1	1	50	361,697	118,565
3	Bronx	Lincoln	1	3		42,159	14,053
2	Brooklyn	Kings County	1	3		99,908	33,303
3	Do	Wyckoff Heights	1	2	118	1,665,229	561,743

3	Canton	Edward J. Noble	1	1	48	830, 409	276, 803
3	Cooperstown	Mary Imogene Bassett	1	5	26	1, 477, 290	492, 430
3	Corning	Corning	1	2	40	834, 028	278, 009
3	Cuba	Cuba Memorial	1	2	42	291, 653	97, 218
3	Dansville	Dansville Memorial	1	2	57	607, 965	202, 655
2	Dunkirk	Brooks Memorial	1	2	38	456, 834	152, 278
2	Far Rockaway	St. Joseph's	1	5	86	1, 720, 800	557, 700
3	Gouverneur	Edward John Noble	1	1	60	1, 166, 074	376, 077
3	Gowanda	Tri County Memorial	1	1	50	456, 408	152, 136
3	Greenport	Eastern Long Island	1	2	19	669, 168	223, 056
3	Hamilton	Hamilton Community	1	1	50	379, 380	126, 460
3	Hornell	St. James Mercy	1	5	58	1, 081, 472	351, 824
2	Hudson	Columbia Memorial	1	2	102	1, 937, 719	645, 906
1	Jamaica	Mary Immaculate	1	5		39, 000	13, 000
2	Do	Queens General	1	2	236	5, 783, 752	1, 318, 963
3	Do	do	1	3		27, 744	9, 248
3	Do	Jamaica	1	2	78	1, 780, 647	593, 549
3	Do	Queens General	1	5		317, 757	105, 919
3	Do	Women's Christian Association	1	5	55	1, 103, 929	367, 976
3	Jamestown	Charles S. Wilson Memorial	1	2		47, 062	15, 687
3	Johnson City	Kingston	1	2	103	750, 000	250, 000
1	Kingston	Benedictine	1	2	93	1, 817, 070	605, 690
3	Do	Ulster County Tumor Clinic	5	1		405, 866	135, 289
3	Do	Placid Memorial	1	1	50	617, 292	205, 764
3	Lake Placid	Liberty Maimonides	1	1	56	731, 040	243, 680
2	Liberty	North Shore Hospital	1	1	186	3, 398, 954	442, 500
2	Manhasset	Massena	1	1	92	1, 195, 527	398, 509
2	Massena	Nassau	*1	2	140	2, 200, 000	348, 000
1	Mineola	Hebrew	1	2	35	231, 231	77, 077
3	Monticello	Shepard Relief	1	5	15	199, 356	66, 452
3	Montour Falls	The Mount Sinai	1	2	168	279, 776	93, 259
2	New York	The Roosevelt	1	2		1, 705, 178	568, 392
2	Do	Harlem	1	3		31, 725	10, 575
3	Do	The Presbyterian	1	3		74, 858	24, 953
3	Do	Bellevue	1	3		52, 323	17, 441
3	Do	St. Vincent's	1	2		91, 780	30, 594
3	Do	The Presbyterian	1	2	15	104, 582	34, 861
3	Do	Oneida	*1	1		56, 997	18, 999
3	Do	do	1	2	68	409, 536	136, 512
3	Oneida	Aurelia Osburn Fox Memorial	1	2		56, 716	18, 905
3	Do	Oswego	*1	2	80	1, 096, 351	365, 450
3	Oneonta	Vassar Brothers	1	5	40	487, 279	118, 368
3	Oswego	St. Francis	*1	2	111	2, 311, 368	535, 179
2	Poughkeepsie	North Dutchess Health Service Center	*1	5	23	169, 026	56, 342
3	Do	Central Suffolk	1	1	58	841, 645	280, 548
3	Rhinebeck	Rochester General	1	1	250	4, 000, 000	1, 306, 666
3	Riverhead	Highland	1	6	71	1, 409, 262	469, 754
1	Rochester	Strong Memorial	*1	5		661, 543	191, 981
2	Do	The Saratoga	1	5	8	320, 793	106, 931
2	Do	Saratoga County Health Center	*5	2		137, 870	18, 892
2	Saratoga Springs	Eastern New York Orth Foundation	1	2	24	257, 781	85, 927
3	Do	Clifton-Fine	7	1	29	341, 835	113, 945
3	Schenectady	Good Samaritan	1	2	48	358, 728	119, 576
3	Star Lake						
3	Suffern						

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	NEW YORK—continued						
3	Syracuse	St. Josephs	1	2	177	$1,847,866	$444,376
2	Troy	St. Marys	*1	2		684,894	133,522
1	Utica	Faxton	*1	2	24	600,000	200,000
1	Do	St. Lukes-Memorial Hospital Center	1	1	220	3,859,000	700,000
1	Do	St. Elizabeth	*1	2	100	2,100,000	500,000
2	Do	Childrens Hospital Home	*4	2	18	251,550	83,850
3	Walton	Delaware Valley	1	1	50	412,671	137,557
2	Warsaw	Wyoming County Memorial Hospital	*1	7	110	1,813,338	604,446
3	Watertown	House of the Good Samaritan	1	4	168	1,726,249	575,416
3	Waverly	Tioga County General	1	2	60	698,558	232,853
3	Wellsville	William and Gertrude Jones Memorial	1	1	58	1,267,998	422,666
	NORTH CAROLINA						
2	Ahoskie	Roanoke-Chowan Hospital	1	2	25	200,000	88,000
3	Do	Roanoke-Chowan	1	1	42	139,653	46,551
3	Do	Roanoke-Chowan Nurses Home	*1	2		106,546	35,515
2	Albemarle	Stanly County Public Health Center	5	1		68,320	22,678
3	Do	Stanly County	1	1	100	1,176,614	392,205
3	Do	Stanly County Nurses Home	*1	2		167,500	73,700
2	Asheville	Memorial Mission	1	5	249	2,856,728	1,256,960
3	Banner Elk	Grace Nurses Home	*1	2		99,528	43,192
3	Belhaven	Pungo District	1	1	20	124,962	41,154
1	Boone	Watauga Hospital Nurses Home	*1	2		84,042	28,574
1	Brevard	Transylvania Community	*1	5	15	200,000	68,000
3	Bryson City	Swain County	1	1	20	158,058	51,602
1	Do	do	*1	2		27,000	9,180
3	Burgaw	Pender Memorial	1	1	25	202,185	85,618
3	Burlington	Alamance County	1	1	100	1,029,859	327,353
2	Do	Alamance County Nurses Home	*1	2		205,567	89,562
3	Carthage	Moore County Public Health Center	5	1		58,120	25,187
2	Chapel Hill	North Carolina Sanatorium	2	1	100	1,236,250	500,000
3	Charlotte	Presbyterian Nurses Home	*1	2		861,199	303,600
2	Do	Mercy	*1	2		861,446	303,600
2	Do	Charlotte Memorial	*1	5	20	613,798	212,520
3	Clinton	Sampson County	1	1	100	1,070,694	349,243
3	Do	Sampson County Nurses Home	*1	2		180,130	72,600
3	Do	Sampson County Health Center	5	1		66,968	29,094
3	Columbia	Tyrrell County Public Health Center	5	1		36,006	15,840
3	Concord	Cabarrus County	*1	5	130	2,327,339	604,375
2	Currituck	Currituck County Health Center	5	1		39,707	17,471
2	Dunn	Harnett Health Center	5	1		33,374	10,205
2	Durham	Watts Hospital	*1	5	105	2,577,476	910,800
2	Do	Lincoln Hospital	*1	5	35	758,000	333,520
3	Do	Duke University Nurses' Home	*1	2		846,000	364,737
3	Do	North Carolina Cerebral Palsy	4	1	40	511,319	150,000
3	Edenton	Chowan	1	1	35	322,128	105,086

3	Do	Chowan Nurses' Home	*1	2		57, 102	25, 080
3	Elizabethtown	Bladen County	1	1	50	719, 257	312, 558
1	Fayetteville	Cumberland County	1	1	150	2, 070, 099	703, 800
3	Gastonia	Gaston Memorial	1	2	100	1, 051, 998	339, 504
3	Goldsboro	Wayne County Memorial	*1	2	100	1, 011, 839	437, 360
3	Do	State U-Shaped F Bldg	3	1	302	519, 746	173, 249
3	Do	State L-Shaped M Bldg	3	1	185	372, 000	124, 000
3	Do	State	*3	2		327. 834	107, 167
3	Do	do	*3	5		250, 049	78, 000
1	Greensboro	Guilford County Health Center	5	1		166, 750	56, 695
2	Do	Moses H. Cone Memorial	1	1	300	4, 728, 056	462, 000
3	Greenville	Pitt County Memorial	1	1	120	1, 418, 591	469, 271
3	Do	Pitt County Memorial Nurses' Home	*1	2		132, 888	58, 471
3	Halifax	Halifax County Public Health Center	5	1		74, 883	29, 348
2	Hendersonville	Margaret R. Pardee Memorial	*1	2		141, 450	48, 093
2	Henderson	Maria Parham	*1	5	31	487, 275	211, 761
2	Do	Maria Parham Nurses' Home	*1	2		131, 000	50, 094
2	Hendersonville	Margaret R. Pardee Memorial	1	1	70	910, 000	400, 400
2	High Point	High Point Memorial Nurses' Home	*1	2		306, 400	104, 176
3	Do	High Point Memorial	1	2	100	985, 928	315, 182
2	Jackson	Northampton County Health Center	5	1		49, 000	21, 560
2	Jacksonville	Onslow County	1	4	50	776, 250	341, 550
2	Jefferson	Ashe County Memorial	*1	5	25	386, 000	169, 840
1	Kenansville	Duplin	1	1	50	776, 250	263, 295
2	Kings Mountain	Kings Mountain Hospital Nurses' Home	*1	2		48, 400	15, 249
3	Do	Kings Mountain	1	1	24	231, 712	82, 569
2	Kinston	Lenoir County Hospital	*1	5	56	1, 190, 750	462, 896
3	Laurinburg	Scotland County Memorial	1	1	100	1, 092, 626	356, 995
3	Do	Scotland County Memorial Nurses' Home	*1	2		200, 894	88, 266
1	Do	Scotland County Health Center	5	1		50, 025	17, 008
3	Lenoir	Caldwell Memorial	1	1	100	1, 041, 368	325, 055
3	Do	Caldwell County Public Health Center	5	1		66, 419	28, 499
2	Lexington	Davidson County Public Health Center	5	1		65, 000	28, 600
2	Louisburg	Franklin County Health Center	5	1		47, 300	20, 812
3	Do	Franklin County	1	1	50	574, 478	184, 399
3	Do	Franklin Memorial Nurses' Home	*1	2		103, 176	44, 022
3	Lumberton	Robeson County Public Health Center	5	3		49, 990	21, 930
1	Do	Robeson County Memorial Nurses' Home	*1	2		341, 350	116, 059
2	Do	Robeson County Memorial	1	1	120	1, 422. 128	594, 699
2	Marion	Marion General Nurses' Home	*1	1		117, 338	39, 895
3	Do	Marion General	1	1	60	699, 021	298, 308
3	McCain	North Carolina Sanatorium	*2	5		107, 166	35, 722
2	Monroe	Union Memorial	1	1	100	1, 306, 129	539, 085
2	Do	do	*1	2		182, 360	62, 002
1	Mooresville	Lowrance	*1	2	31	650, 000	221, 000
2	Morganton	Burke County Health Center	5	1		66, 700	22, 678
3	Do	Grace	*1	2		73, 877	30, 800
3	Do	State Employees Building	3	4		204, 714	66, 563
2	Do	Grace	*1	5	40	479, 403	206, 097
3	North Wilkesboro	Wilkes General	1	1	100	945, 989	405, 995
2	Do	Wilkes General Nurses' Home	*1	2		188, 000	63, 920
2	Oxford	Granville County Hospital	*1	5	54	690, 000	303, 600
3	Plymouth	Washington County	1	1	20	184, 501	59, 896

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	NORTH CAROLINA—continued						
2	Raleigh	The Rex Hospital	*1	2		$277,748	$110,000
3	Do	St. Agnes	*1	4		86,356	36,924
2	Reidsville	Rockingham County Health Center	5	1		47,600	16,184
2	Do	Annie Penn Memorial	*1	5		350,000	154,000
2	Rockingham	Richmond County Memorial	1	1	50	631,000	264,000
2	Do	do	*1	2		102,700	28,574
2	Roxboro	Person County Health Center	5	1		40,800	13,872
3	Do	Person County Memorial	1	1	60	799,003	240,000
3	Do	Person County Memorial Nurses' Home	*1	2		98,836	43,488
3	Rutherfordton	Rutherford County Public Health Center	5	1		66,490	28,628
2	Do	Rutherford	1	5	70	778,769	334,007
2	Salisbury	Rowan Memorial Nurses' Home	*1	2		304,000	103,394
2	Do	Rowan County Health Center	5	1		237,821	40,354
2	Do	Rowan Memorial	*1	5	88	1,260,000	539,742
2	Sanford	Lee County Hospital	1	5	29	388,125	170,775
3	Scotland Neck	Halifax County Community Clinic	1	1	20	161,484	53,333
2	Shelby	Shelby	*1	5	36	600,053	264,000
3	Siler City	Chatham	1	1	50	623,000	200,000
3	Do	Chatham Nurses' Home	*1	2		81,912	36,041
3	Smithfield	Johnston Memorial Nurses' Home	*1	2		203,500	87,441
2	Do	Johnston Memorial	1	1	100	1,032,000	339,878
2	Snow Hill	Greene County Public Health Center	5	1		51,872	19,810
1	Southport	J. Arthur Dosher Memorial	*1	5		110,000	37,400
3	Sparta	Alleghany County Memorial	1	1	20	159,529	52,082
2	Statesville	Iredell Memorial	1	1	100	1,177,000	400,180
2	Tarboro	Edgecombe County Public Health Center	5	1		66,700	29,348
3	Taylorsville	Alexander County	1	1	20	201,303	61,333
2	Thomasville	City Memorial Hospital	1	2	65	614,000	259,578
3	Troy	Montgomery County	1	1	40	538,480	160,000
2	Tryon	St. Lukes Hospital	1	5	15	177,000	58,650
2	Wadesboro	Anson County	1	4	50	708,400	240,856
2	Warrenton	Warren County Health Center	5	1		40,880	17,991
3	Do	Warren County	1	1	35	358,452	111,551
3	Washington	Beaufort County Public Health Center	5	1		64,715	28,153
2	Waynesville	Haywood County	*1	5	49	671,000	295,240
1	Whiteville	Columbus County Nurses' Home	*1	1		80,040	27,214
2	Do	Columbus County	*1	5	18	443,780	195,263
3	Williamston	Martin County Public Health Center	5	1		53,474	22,011
3	Windsor	Bertie County Memorial	1	1	50	630,900	267,742
3	Winton	Hertford County Public Health Center	5	1		50,025	21,517
2	Yadkinville	Lula Conrad Hoots	1	1	30	353,449	151,800
3	Yanceyville	Caswell County Public Health Center	5	1		38,540	16,659

	NORTH DAKOTA						
3	Ashley	McIntosh County Memorial	1	1	14	257,340	119,663
3	Bowman	Bowman Community	1	1	16	340,481	113,413
2	Cando	Towner County Memorial	1	1	20	457,073	210,254
2	Cavalier	Pembina County Memorial	1	1	22	290,462	133,613
3	Cooperstown	Griggs County	1	1	26	410,219	136,404
3	Elgin	Elgin Memorial	1	1		30,149	10,050
3	Ellendale	Dickey County	1	1		213,643	21,769
3	Garrison	Garrison Community	1	1	28	434,765	144,922
3	Hettinger	Hettinger Community Memorial	1	1	28	320,010	98,777
3	Lisbon	Lisbon Community Memorial	1	1	20	237,550	110,460
3	Maddock	Maddock Memorial	1	1	20	244,261	111,349
3	Mohall	Renville Botteneau Memorial	1	1		252,372	31,217
3	Stanley	Stanley Community	1	1	21	281,548	127,200
3	Turtle Lake	Turtle Lake Community	1	1		109,411	12,323
3	Watford City	McKenzie County Community	1	1	18	249,159	83,027
2	Wishek	Wishek	1	1	16	253,414	116,489
	OHIO						
2	Akron	City Hospital of Akron	1	5	75	1,522,547	121,992
2	Do	Peoples	*1	5	245	4,585,487	1,075,361
2	Alliance	Alliance City	*7	5	119	1,643,853	547,951
2	Ashland	Samaritan	1	7	42	723,220	209,250
2	Ashtabula	Ashtabula General	1	1	100	1,786,218	595,406
2	Barberton	Barberton Citizens	*7	1	155	2,789,344	929,781
2	Barnesville	Barnesville	1	6	35	368,317	122,772
2	Bay Village	Bay View	1	5	30	371,696	120,357
3	Bellefontaine	Mary Rutan	1	2	34	436,740	101,715
2	Bellevue	Bellevue	1	5	22	404,741	134,914
3	Bowling Green	Wood County	1	1	54	839,767	279,922
2	Cambridge	Guernsey Memorial	7	1	84	1,185,910	395,304
2	Canton	Timken Mercy	1	2		470,000	23,333
2	Do	Molly Stark Sanatorium	2	2	108	803,256	267,752
2	Chillicothe	The Chillicothe	1	5	51	1,030,039	343,346
2	Cincinnati	Hamilton County Chronic Disease	4	1	380	4,695,528	1,195,528
1	Cleveland	Fairview Park	1	1	188	4,215,250	1,200,000
2	Columbus	Columbus Health Center	5	1		1,106,482	316,367
3	Conneaut	Brown Memorial	1	5	35	561,240	187,080
1	Cuyahoga Falls	Green Cross General	1	1	50	600,000	200,000
2	Dayton	St. Elizabeth's	1	5	174	3,990,087	1,003,208
2	Do	Good Samaritan	*1	5	155	1,538,961	512,987
3	Defiance	The Defiance	*7	1	66	999,303	333,101
2	Dover	Union	7	5	66	1,247,714	415,905
2	East Toledo	St. Charles'	1	1	201	5,173,588	1,136,317
2	Elyria	Elyria Memorial	1	5	118	1,616,774	538,925
2	Euclid	Euclid-Glenville	1	1	172	3,319,676	1,050,725
2	Galion	Galion City	1	2	25	267,794	52,351
2	Garfield Heights	Marymount	1	1		101,497	33,832
3	Geneva	Memorial	1	1	24	399,509	133,170
2	Georgetown	Brown County	1	1	42	580,046	193,348
2	Ironton	Lawrence County General	1	2		103,821	34,607
3	Kenton	Hardin Memorial	1	1	44	509,068	154,689
2	Lorain	St. Joseph	1	2	68	765,178	255,059

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	OHIO—continued						
3	Mansfield	Richland County TB Sanatorium	2	1	84	$777,533	$388,333
2	Marietta	Marietta Memorial	1	5	52	688,507	229,502
2	Marysville	Union County	7	1	25	586,500	195,500
3	Nelsonville	Mount St. Mary	7	1	74	1,264,901	421,634
2	Newark	Newark Hospital	1	5	61	639,649	171,623
2	Oak Hill	Oak Hill Community Medical Center	1	1		126,685	8,895
2	Montpelier	Williams County Joint Township	7	1	35	686,401	193,967
2	Mount Vernon	Mercy	1	2	86	1,901,959	333,987
2	Portsmouth	do	*1	2		760,656	229,518
3	Do	do	1	5		1,624,000	82,778
2	Sandusky	Providence	1	5	62	1,139,920	379,973
3	Do	Good Samaritan	1	5	47	939,097	313,032
3	Springfield	Mercycrest	1	1		319,640	106,547
2	St. Mary's	Joint Township District	1	1	50	772,101	257,367
2	Toledo	Civic Health Center	5	1		1,087,642	362,547
3	Do	St. Vincent's	1	2		487,888	162,629
3	Do	Robinwood	1	2		636,273	48,425
3	Upper Sandusky	Wyandot Memorial	1	1	25	417,547	139,182
3	Urbana	Mercy Memorial	1	1	50	899,427	299,809
2	Warren	Trumbull Memorial	*1	2	166	2,779,247	785,981
2	Warrensville Heights	Cuyahoga County Chronic	4	2	440	5,254,905	829,367
3	Washington C. H.	Fayette Memorial	7	1	32	638,000	210,000
2	West Union	Adams County	1	1	22	375,000	125,000
3	Willard	Willard Municipal	1	2		58,123	19,374
3	Wilmington	Clinton Memorial	1	1	65	917,861	305,953
3	Wooster	Wooster Community	7	1	70	1,466,680	196,426
3	Xenia	Greene County Memorial	7	1	75	1,356,679	440,560
1	Youngstown	St. Elizabeth	*1	2	125	3,983,278	892,000
2	Do	Youngstown	*1	2	149	2,861,605	953,869
	OKLAHOMA						
3	Altus	Jackson County	1	1	55	459,054	151,553
1	Ardmore	Southern Oklahoma Memorial	1	1	100	1,500,000	625,000
3	Bartlesville	Washington County Memorial	1	5	42	846,850	275,837
2	Beaver	Beaver County	7	1	25	386,725	198,607
3	Bethany	Child Convalescent Home	4	5	23	152,873	81,600
1	Blackwell	Blackwell	1	1	60	803,000	387,500
3	Boise City	Cimarron County Community Clinic	1	1	20	249,300	148,455
3	Clinton	Western Oklahoma Tubercular Sanitorium	2	2	129	741,913	415,928
3	Do	do	2	2	80	54,996	29,287
3	Coalgate	Coal County General	1	1	14	112,272	64,418
3	Cushing	Cushing Municipal	1	5	31	366,070	122,023
1	El Reno	El Reno Municipal	1	1	40	550,000	209,995
3	Enid	St. Marys	1	2	99	1,666,748	590,472
3	Fairfax	Fairfax Municipal	1	1	23	178,643	58,803
2	Fort Supply	Western State Hospital	3	2	200	663,377	358,124

3	Do	do	3	2	150	341,462	188,582
3	Do	do	3	2	88	350,582	198,085
3	Do	do	3	2	77	310,031	140,408
3	Guymon	Guymon City	1	1	25	280,677	93,559
3	Hugo	Choctaw County Health Center	7	1	30	282,698	97,566
1	Idabel	McCurtain County	1	1	25	310,000	150,000
3	Kingfisher	Community	1	1	20	183,790	58,591
3	Lawton	Comanche County Memorial	*1	1	100	935,600	308,000
3	McAlester	Central State Hospital	1	3	69	260,002	86,653
2	Miami	Ottawa County Health Center	5	4		33,920	16,960
3	Muskogee	City-County Health Department	*5	2		20,000	12,000
3	Norman	Central State Hospital	3	2	54	490,884	162,568
3	Do	do	3	3	35	372,706	124,235
3	Do	do	*3	5		1,185,421	392,371
3	Do	do	3	2	188	665,902	366,917
3	Do	do	3	2	183	360,511	187,794
3	Do	do	3	2	188	673,404	354,105
3	Nowata	Nowata	1	1	30	149,405	48,135
3	Okarche	Okarche Memorial	1	1		33,723	11,241
3	Okeene	Okeene Municipal	1	4	20	239,719	127,693
3	Okemah	Okfuskee County	1	1	35	294,392	95,447
1	Oklahoma City	Mercy	1	5	17	260,000	125,000
2	Do	University of Oklahoma School of Medicine	1	2	75	1,495,597	897,359
3	Do	Edwards Memorial	1	1		84,486	28,162
3	Do	University of Oklahoma School of Medicine	1	5		105,261	35,087
3	Do	Mercy Hospital	*1	4		360,818	120,273
3	Do	Crippled Children's	1	2		22,442	7,481
3	Do	University of Oklahoma School of Medicine	*1	2		254,752	152,851
3	Do	State Department Health Laboratory	8	2		65,833	21,944
3	Do	do	*8	2		20,322	5,322
3	Do	do	8	3		170,453	102,272
3	Perry	Perry Municipal	1	1	28	365,009	207,272
3	Ponca City	Kay County Health Center	5	1		179,337	97,593
3	Poteau	Leflore County Memorial	1	1	40	372,544	124,181
3	Sallisaw	Sequoyah County	1	1	24	101,765	33,921
3	Seminole	Seminole Memorial Hospital	1	2	31	258,899	154,823
3	Stillwater	Stillwater Municipal	1	2	45	400,089	133,363
3	Do	do	1	2	17	97,070	57,837
3	Stilwell	Stilwell Community Clinic	7	1	18	182,318	105,947
3	Talihina	Eastern Oklahoma TB Sanatorium	2	2	66	397,316	238,390
3	Do	do	*2	2		152,230	91,338
3	Do	do	2	2	45	416,953	250,172
3	Thomas	Thomas Memorial	1	1		34,691	20,814
2	Tulsa	Junior League Childrens	4	1		195,471	27,820
3	Do	Hillcrest Memorial	*1	2		272,192	90,731
3	Do	do	1	5	152	1,952,879	1,151,480
3	Vinita	Eastern State Hospital	3	1	30	112,500	37,500
3	Do	do	3	2	200	502,832	282,895
3	Do	do	3	2	111	364,261	205,956
3	Do	do	3	2	111	375,106	214,346
3	Watonga	Watonga Municipal	1	1	20	199,080	66,360
3	Wewoka	Seminole County Headquarters	5	1		127,012	42,337
3	Woodward	Woodward Memorial	1	1	47	544,663	320,497

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	OREGON						
3	Bend	St. Charles Memorial	1	2	55	$928,904	$309,635
3	Burns	Harney County	1	1	31	321,122	106,374
2	Corvallis	Good Samaritan	*1	2	36	266,800	88,935
3	Cottage Grove	Cottage Grove	1	1	30	308,515	102,505
3	Enterprise	Wallowa Memorial	1	1	30	301,169	100,390
3	Eugene	Sacred Heart General	1	2	126	1,500,000	500,000
3	Gold Beach	Curry County	1	1	11	140,441	45,272
3	Heppner	Morrow County	1	1	15	236,159	78,720
3	Lebanon	Lebannon Community	1	1	49	674,053	193,667
2	Newport	Pacific Communities	1	1	17	281,615	91,401
2	Portland	Emanuel	1	2	134	2,017,556	418,884
3	Do	Good Samaritan	1	5	341	2,187,000	729,000
3	Do	Oregon State Hygiene Laboratory	8	1		2,406,638	100,000
3	Roseburg	Douglas Community	1	1	43	569,946	181,664
3	Do	Mercy	1	2	47	415,823	188,608
1	Salem	Salem Memorial	1	5	42	268,398	89,466
2	Do	Salem	1	2	60	974,964	307,821
3	Do	Eastern Oregon State	*3	2		44,008	14,669
3	Do	Oregon State Hospital	3	2	130	779,410	269,803
2	Stayton	Santiam Memorial	1	1	34	374,156	124,719
3	Tillamook	Tillamook County	1	1	75	1,185,918	391,398
	PENNSYLVANIA						
2	Altoona	Altoona	*1	2	104	1,368,823	547,529
3	Do	do	*1	4		782,719	260,907
3	Bedford	Memorial of Bedford County	*1	1	85	1,304,340	493,822
2	Bellefonte	Cerntre County	*1	5	62	1,192,684	477,073
3	Bradford	Badford	1	5	50	1,893,114	681,038
3	Brookville	Brookville	*1	5	38	487,689	153,549
2	Bryn Mawr	Bryn Mawr	*1	2		896,484	358,594
2	Butler	Butler County Memorial	*1	5	29	3,298,884	1,319,553
1	Cannonsburg	Cannonsburg General	*1	5	53	781,789	302,715
3	Carlisle	Carlisle	1	2	48	1,000,135	178,557
3	Chambersburg	The Chambersburg	1	2	129	1,911,124	637,041
3	Clearfield	Clearfield	*1	5	54	1,303,917	434,639
3	Corry	Corry Memorial	1	1	50	729,309	243,103
3	Danville	George F. Geisinger Memorial	*1	2	25	1,492,926	497,642
3	East Stroudsburg	General Hospital of Monroe County	*1	5	38	1,332,765	436,115
2	Easton	Easton Hospital	*1	5	103	1,803,478	721,391
2	Do	Easton Hospital Nurses Home	*1	2		388,501	155,400
2	Greensburg	Westmoreland	*1	5	28	2,259,610	903,844
2	Grove City	Grove City	*1	5	27	670,137	268,055
2	Harrisburg	Harrisburg Polyclinic	*1	5	167	2,991,162	1,196,465
2	Do	Harrisburg	*1	5	138	4,124,000	1,649,600
3	Honesdale	Wayne County Memorial	*1	1	61	810,947	270,316
3	Huntingdon	J. C. Blair Memorial	*1	5	92	1,132,198	377,399

2	Kittanning	Armstrong County	1	5	55	877,057	343,963
2	Lancaster	Lancaster General	*1	5	205	2,673,886	891,295
2	Do	Lancaster Osteopathic	1	2	34	736,807	294,723
2	Do	St. Josephs Hospital	*1	1	265	3,595,390	1,438,156
3	Lehighton	Gnaden Huetten Memorial	*1	1	50	768,785	256,262
2	Lewisburg	Evangelical Community	*1	1	85	1,160,231	464,092
3	Lewistown	Lewistown	*1	5	154	2,154,344	717,615
2	Lock Haven	Lock Haven Nurses Training School	*1	2		220,469	66,708
3	McKees Rocks	Ohio Valley General	1	1	125	1,146,250	80,356
2	McKeesport	McKeesport	*1	2	161	1,900,200	760,080
2	Meyersdale	Community Hospital	1	1	34	513,970	186,958
2	Monongahela	Monongahela Memorial	*1	5	49	1,017,532	406,533
2	Mount Lebanon	St. Clair Memorial	1	1	100	1,563,830	593,786
1	New Brighton	Beaver Valley General Hospital	*1	5	46	626,000	250,000
2	New Kensington	Citizens General	*1	5	118	1,757,565	665,521
2	North Charleroi	Charleroi-Monessen	*1	5	81	1,368,919	547,568
2	Norristown	Montgomery	*1	6		999,244	399,698
2	Philadelphia	Frankford	*1	5	40	1,061,169	424,468
2	Do	Women's Medical College of Pennsylvania	*1	5	42	716,454	286,581
2	Do	Diagnostic Center University of Pennsylvania	*1	5		6,497,743	1,821,327
2	Do	Chestnut Hill	1	2	72	803,696	266,613
2	Do	Wills Eye Hospital	*1	5		30,407	12,163
2	Do	Methodist Episcopal	*1	5		271,304	108,522
2	Phoenixville	Phoenixville	*1	5	64	462,574	185,029
3	Pittsburgh	Home for Crippled Children	*4	2	60	785,017	314,007
2	Pittston	Pittston School of Nursing	*1	5		320,888	128,355
1	Pottstown	Pottstown	*1	5	95	2,050,252	820,100
3	Pottsville	Pottsville	*1	5	83	1,476,317	538,600
2	Reading	St. Josephs Hospital	*1	2		950,221	379,578
1	Rochester	Rochester	*1	5	75	710,000	274,000
2	Spangler	Miners Hospital North Cambria	*1	5	89	724,187	289,674
3	Sunbury	Sunbury Community	*1	1	128	1,595,481	531,827
3	Upper Darby	Delaware County	*1	5	32	708,437	236,146
2	Warren	Warren General	*1	5	46	1,537,102	614,841
2	Williamsport	Williamsport	*1	5	29	800,860	320,344
3	Do	City County Way Memorial Isolation	1	2	16	173,854	57,951
3	Do	Williamsport	*1	5	46	1,410,293	452,999
	RHODE ISLAND						
2	Cranston	Osteopathic General	1	1	24	300,836	60,000
2	Newport	Newport	*1	2		38,400	15,360
3	Do	do	*1	2		120,714	16,738
2	Pawtucket	The Memorial	1	5	56	504,418	201,767
2	Providence	Miriam	1	1	150	1,715,358	670,143
2	Do	Roger Williams General	*1	2	48	975,937	390,374
2	Do	Our Lady of Fatima	*4	4		3,292,126	300,000
3	Warwick	Kent County Memorial	*1	1	86	1,244,354	431,742
2	Woonsocket	Woonsocket	1	5	31	1,128,307	280,704

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	SOUTH CAROLINA						
3	Aiken	Aiken County	1	2	50	$482,676	$150,626
3	Anderson	Anderson County Public Health Center	5	1		160,025	53,341
3	Andrews	Andrews Health Center	6	1		13,969	4,656
3	Bamberg	Bamberg County Memorial	*1	1	32	514,108	334,170
3	Barnwell	Barnwell County Health Center	5	1		93,857	30,427
3	Batesburg-Leesville	Lexington County Auxiliary Health Center	6	1		28,472	18,507
3	Bethune	Bethune Health Center	6	1		11,024	6,063
3	Bishopville	Lee County General	*1	1	43	537,424	295,583
3	Do	Lee County Public Health Center	5	1		39,076	13,025
3	Blaney	Blaney Health Center	6	1		11,933	6,563
3	Bluffton	Bluffton Health Center	6	1		13,165	7,241
3	Boykin	Boykin Health Center	6	1		11,534	6,344
3	Brittons Neck	Brittons Neck Health Center	6	1		16,366	8,182
3	Buford	Buford Health Center	6	1		17,822	9,802
3	Canadys	Canadys	6	1		9,895	6,432
3	Central	Central Health Center	6	1		36,531	21,918
3	Chapin	Chapin Health Center	6	1		27,901	18,136
2	Charleston	Charleston County Tuberculosis	2	1	70	1,154,870	574,360
3	Do	Medical College of State of South Carolina	*1	1	264	9,567,450	5,851,202
3	Cheraw	Cheraw Health Center	6	1		44,364	28,837
3	Chesterfield	Chester County	1	1	74	941,368	468,827
3	Columbia	Chester County Health Center	5	1		74,974	24,991
3	Do	Chesterfield County Health Center	5	1		63,489	41,268
3	Do	Good Samaritan Waverly	1	1	42	229,649	134,302
3	Do	South Carolina State Hospital	*3	3		60,840	20,280
3	Do	do	*3	2		72,023	24,008
3	Do	do	*3	1		215,870	71,957
3	Cottageville	do	*3	2		132,457	79,475
3	Easley	South Carolina State	3	2	50	174,299	104,580
3	Edgefield	Cottageville Health Center	6	1		9,896	6,432
3	Fairfax	Easley Health Center	6	1		32,832	19,699
1	Florence	Edgefield County Health Center	5	1		65,806	21,935
3	Do	Allendale County	1	1		58,984	32,441
3	Georgetown	Florence Darlington Tuberculosis	*2	1		84,210	44,210
3	Do	Florence Darlington Tuberculosis Sanitarium	2	1	118	842,000	442,050
3	Georgetown	Georgetown County Memorial	1	1	52	529,954	173,864
3	Grays	do	*1	2		60,472	33,259
3	Great Falls	Georgetown County Health Center	5	1		57,972	19,324
3	Greeleyville	Grays Health Center	6	1		11,620	6,391
3	Green Pond	Great Falls Health Center	6	1		15,404	5,135
2	Greenville	Greeleyville Public Health Center	6	1		21,355	10,677
3	Do	Green Pond Health Center	6	1		9,341	6,072
3	Greer	Greenville General	1	2	267	4,174,636	1,828,011
3	Hampton	do	*1	2		342,698	171,350
		Allen Bennett Memorial	1	1	28	501,860	175,000
		Hampton County	1	1	25	292,124	91,541

9	Hampton	Hampton County	1	1	25	292,124	175,000	91,541

3	Heath Springs	Heath Springs Health Center	6	1		16,935	9,314	
3	Hemingway	Hemingway Public Health Center	6	1		20,292	10,146	
3	Hendersonville	Hendersonville Health Center	6	1		10,059	6,538	
3	Islandton	Islandton Health Center	6	1		10,305	6,640	
3	Jacksonboro	Jacksonboro Health Center	6	1		9,742	6,333	
3	Jefferson	Jefferson Health Center	6	1		18,810	12,226	
3	Johnston	Johnston Public Health Center	6	1		36,643	12,215	
3	Kershaw	Kershaw Auxiliary Health Center	6	1		34,437	18,940	
3	Kingstree	Williamsburg County Health Center	5	1		68,522	34,261	
3	Lancaster	Lancaster County Public Health Center	5	1		96,457	32,152	
3	Lando	Lando Health Center	6	1		12,138	4,046	
3	Laurens	Laurens County Health Center	5	1		158,076	86,942	
3	Lexington	Lexington County Health Center	5	1		126,572	82,272	
3	Lodge	Lodge Health Center	6	1		9,547	6,206	
3	Loris	Loris Community	1	1	25	165,496	55,165	
3	Lowrys	Lowrys Health Center	6	1		12,572	4,191	
2	Manning	Clarendon Memorial	*1	2		66,256	39,754	
3	Do	Clarendon County	1	1	52	582,129	191,773	
3	McBee	McBee Health Center	6	1		18,310	11,902	
3	McClellanville	McClellanville Health Center	6	1		11,319	5,660	
3	Moncks Corner	Berkeley County Health Center	5	1		97,527	32,509	
3	Mount Croghan	Mount Croghan Health Center	6	1		18,262	11,870	
3	Mullins	Mullins Health Center	6	1		4,497	2,248	
3	Nesmith	Nesmith Public Health Center	6	1		14,241	7,120	
3	Newberry	Newberry County	1	5	38	360,032	120,010	
3	Do	do	*1	2		45,794	25,186	
3	Pageland	Pageland Health Center	6	1		37,826	24,586	
3	Patrick	Patrick Health Center	6	1		18,312	11,903	
3	Pickens	Pickens County Health Center	5	1		99,352	59,611	
3	Pleasant Hill	Pleasant Hill Health Center	6	1		16,218	5,406	
3	Richburg	Richburg Health Center	6	1		12,496	4,165	
3	Ridge Spring	Ridge Spring Health Center	6	1		20,815	6,938	
3	Ridgeland	Ridgeland Public Health Center	5	1		49,346	27,140	
2	Rock Hill	York County	1	5	37	491,433	245,717	
3	Do	do	*1	2	62	541,103	180,368	
3	Ruby	Ruby Health Center	6	1		18,210	11,836	
3	Ruffin	Ruffin Health Center	6	1		10,016	6,510	
3	Saluda	Saluda County Public Health Center	5	1		67,757	22,586	
3	Seneca	Oconee Memorial	1	2	40	151,078	50,359	
3	Sheldon	Sheldon Health Center	6	1		12,933	7,113	
3	Smoaks	Smoaks Health Center	6	1		9,856	6,406	
3	Spartanburg	Spartanburg	1	5	64	1,374,650	458,217	
3	Do	Spartanburg General	*1	5		124,941	62,470	
3	St. Matthews	Calhoun County Public Health Center	5	1		98,000	32,667	
3	State Park	South Carolina Sanatorium	2	5	143	469,788	156,596	
3	Do	South Carolina State Sanatorium	2	2	64	105,504	52,751	
3	Do	do	*2	5		28,575	14,287	
3	Do	do	*2	2		26,026	13,013	
3	Do	do	*3	1		17,585	5,862	
3	Do	South Carolina State Hospital	3	5		63,080	21,027	
3	Do	do	3	2	160	487,284	162,429	
3	Do	do	*3	1		107,991	35,997	
3	Do	do	3	2	80	120,027	78,017	
3	Do	South Carolina State						

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	SOUTH CAROLINA—continued						
2	Sumter	The Tuomey Hospital	1	2	56	$676,311	$301,311
3	Swansea	Swansea Health Center	6	1		27,605	17,943
3	Trio	Trio Public Health Center	6	1		14,522	7,261
3	Union	Union County	1	5	60	733,715	244,572
3	Do	Union County Health Center	5	1		91,764	50,471
2	Walterboro	Colleton County Health Center	5	2		22,757	14,791
3	Do	Colleton County	*1	1	101	1,077,628	669,705
3	Do	Colleton County Health Center	5	1		76,927	25,308
3	West Columbia	Lexington County Health Center	6	1		38,336	24,919
1	Winnsboro	Fairfield County	1	1	30	452,413	224,413
	SOUTH DAKOTA						
2	Chamberlain	Community Bailey	1	1	30	259,036	86,345
2	Deadwood	St. Josephs Hospital	1	2		424,742	32,660
2	Faulkner	Faulk County	1	1	23	242,340	80,700
2	Freeman	Freeman Community	1	1	19	209,000	104,500
2	Gettysburg	Gettysburg Memorial	1	1	20	337,225	149,363
2	Gregory	Gregory	1	1	24	213,241	104,522
2	Lemmon	Five Counties	1	1	34	303,533	101,001
2	Mitchell	Methodist State	*1	5	15	512,637	169,941
2	Do	St. Joseph's Hospital	1	5	60	657,089	204,798
2	Pierre	State Department Health Laboratory	8	2		108,687	46,687
2	Rapid City	Bennett Memorial	1	5	55	1,030,000	275,000
2	Do	St. Johns McNamara	1	5	50	987,380	247,131
2	Redfield	Redfield Municipal	1	1	36	358,545	118,528
2	Sturgis	Sturgis Community Hospital	1	1	20	244,598	119,893
3	Winner	Rosebud Community	1	1	28	298,562	91,988
	TENNESSEE						
3	Athens	McMinn County Health Center	5	1		51,924	27,000
2	Bristol	Kings Mountain Memorial	1	1	70	1,444,121	673,033
3	Camden	Benton County Health Center	5	1		66,608	34,636
2	Chattanooga	Baroness Erlanger	1	2	66	820,943	410,171
3	Do	Chattanooga TB	2	1	120	2,098,360	699,453
2	Clarkesville	Clarkesville	1	1	100	2,475,262	960,000
3	Cleveland	Bradley County Health Center	5	1		65,221	33,642
2	Do	Bradley County	1	1	51	986,425	481,712
2	Clinton	Anderson County Health Center	5	1		65,000	33,800
2	Columbia	Maury County and Health Center	7	1	100	2,227,230	845,000
3	Cookeville	Cookeville	1	1	49	600,142	189,047
3	Crossville	Cumberland Medical Center	1	1	50	707,860	235,787
3	Decaturville	Decatur County Health Center	5	1		78,910	40,552
2	Erwin	Unicoi County Memorial	1	1	40	557,696	223,200
3	Fayetteville	Lincoln County	1	2	35	497,409	164,750

1	Hartsville	Trousdale County Health Center	5	1		50,000	26,000
2	Jackson	Jackson-Madison County	1	2	57	629,840	314,413
3	Do	Jackson and Madison County	7	1	128	1,838,993	589,880
3	Johnson City	Johnson City Memorial	1	2	84	1,245,265	408,488
3	Do	do	1	2	36	113,736	59,143
1	Jonesboro	Washington County Health Center	5	1		65,000	33,800
3	Kingsport	Holston Valley Community	1	2	126	2,100,852	817,002
1	Kingston	Roane County Health Center	5	1		60,000	31,200
3	Knoxville	Eastern State	3	2	188	1,579,339	421,446
3	Do	Eastern Tennessee Crippled Children	4	5	40	523,846	267,332
3	Do	Eastern Tennessee TB	2	4	180	3,249,422	1,089,229
3	Lawrenceburg	Lawrence County	7	1	50	527,548	172,349
2	Manchester	Coffee County	1	1	61	799,662	410,325
2	Maryville	Blount County Health Center	5	1		80,000	41,600
3	Do	Blount Memorial	1	5	62	576,921	192,307
3	Memphis	Western Tennessee TB	2	1		285,048	95,016
3	Do	Lebonheur Children's	4	1	100	2,195,761	1,104,721
3	Morristown	Hamblen County Health Center	5	1		47,543	24,722
1	Mountain City	Johnson County Health Center	5	1		50,000	26,000
3	Murfreesboro	Rutherford	1	5	32	508,439	235,600
3	Nashville	Central State	3	2		70,000	36,400
2	Do	Middle Tennessee TB	2	1	226	4,520,676	2,347,215
2	Do	State Department Health Laboratory	8	1		8,070,550	606,190
2	Paris	Henry County General	1	1	71	1,034,035	534,832
3	Pulaski	Giles County Hospital and Health Center	7	1	41	414,778	131,826
1	Ripley	Lauderdale County	1	2	14	100,000	52,000
3	Do	do	1	1	55	531,746	172,249
3	Savannah	Hardin County	7	1	50	797,150	405,158
3	Sewanee	Emerald Hodgson	*1	3		150,446	78,232
3	Shelbyville	Bedford County	7	1	58	863,905	438,831
3	Sneedville	Hancock County Hospital and Health Center	7	1	11	242,083	125,883
2	Union City	Obion County	1	2	35	400,000	208,000
3	Do	do	1	1	60	760,158	251,310
2	Waverly	Humphreys County Health Center	5	1		54,314	27,378
	TEXAS						
3	Albany	Shackelford County Memorial	1	1	16	139,027	46,342
2	Amarillo	Northwest Texas	*1	5	100	1,529,625	764,812
3	Andrews	Andrews County	1	1		105,794	12,596
3	Anson	Anson General	1	1	30	343,000	170,000
1	Austin	Brackenridge	*1	2	110	2,989,878	750,000
1	Do	St. Davids	*1	1	100	1,420,000	680,000
1	Do	City of Austin Public Health Unit	5	1		200,000	100,000
2	Do	Seton	1	5	63	800,000	400,000
3	Do	Holy Cross	1	1	40	634,189	206,259
3	Do	State Department of Health Laboratory	8	2		89,795	29,932
3	Big Lake	Reagan County Memorial	1	1	10	173,974	56,740
3	Breckenridge	Stephens County	1	1	17	221,550	110,775
1	Brenham	St. Jude Hospital	*1	1	34	558,500	270,000
3	Brownfield	South Plains Health Unit	5	1		81,658	40,454
3	Brownsville	Mercy	1	5	56	898,483	444,125
1	Bryan	St. Josephs Hospital	*1	2	48	820,400	400,000
3	Canadian	Hemphill County	1	1	16	156,901	49,804

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	TEXAS—continued						
3	Carrizo Springs	Dimmit County	*1	1	27	$312,828	$103,809
3	Carthage	Panola County	1	1	50	558,618	182,668
3	Childress	Childress General	1	5	29	145,491	45,796
3	Cleburne	Johnson County Memorial	*1	2		21,098	10,549
2	Corpus Christi	Driscoll Hospital for Children	*1	2	102	3,690,000	1,500,000
2	Do	Nueces County Tuberculosis	2	1	100	875,000	430,000
2	Do	Corpus Christi Memorial	*1	5	150	1,500,000	750,000
3	Do	Spohn	1	2	108	1,630,000	522,000
3	Corsicana	Navarro County Memorial	*1	1	100	1,648,600	816,300
2	Crowell	Foard County	1	5	7	153,929	76,900
2	Dallas	Memorial Hospital	1	1	564	9,984,810	1,500,000
3	Denison	Madonna	1	2	16	111,474	54,825
3	Denton	Flow Memorial	1	1	60	816,000	256,371
3	Dumas	Moore County	1	1	28	420,052	106,278
2	El Paso	Hotel Dieu Sisters	1	5	149	3,580,000	1,525,000
3	Do	Providence Memorial	1	1	272	3,107,238	1,459,694
3	Do	El Paso General	1	2	30	240,000	120,000
1	Empty Jug	McCarter Memorial	*1	1	11	182,090	61,000
2	Falfurrias	Brooks County	1	1	31	517,500	253,000
2	Galveston	John Sealy	1	2	769	12,008,680	2,250,000
2	Do	Rosa-Henry-Ziegler	2	1	60	817,000	404,500
3	Ganado	Mauritz Memorial	1	1	28	332,810	108,799
3	Do	Mauritz Memorial Jackson County	*1	2		77,936	38,968
3	Giddings	Lee Memorial	1	1	16	148,749	49,583
3	Goliad	Goliad County	1	1	14	170,884	55,628
1	Gonzales	Warm Springs Childrens	*4	5	40	658,956	281,778
2	Haskell	Haskell County Hospital	1	5	16	205,000	102,500
3	Hempstead	Waller County	1	1	28	300,865	144,395
3	Henrietta	Clay County Memorial	1	5	30	98,559	19,625
3	Hereford	Deaf Smith County	1	5	16	245,639	55,115
2	Houston	M. D. Anderson Cancer	4	1	300	8,243,150	2,025,000
2	Do	Hedgecroft Memorial and Clinic	*4	2	24	310,575	142,500
2	Do	Canal Street Health Center	5	1		197,000	97,000
3	Do	Jefferson Davis	1	2	60	220,176	100,000
3	Do	Hedgecroft Memorial	*4	1		367,783	41,392
3	Huntsville	Houston Public Health Center	5	1		212,974	99,550
3	Iraan	Huntsville Memorial	1	1	50	375,232	125,077
3	Karnes City	Pecos County	*1	1	14	126,324	51,324
3	Kilgore	Karnes City	1	1	13	181,853	60,618
3	Kingsville	Kilgore Memorial	1	1	75	1,450,605	459,421
2	Kountze	Kleberg County	*1	5		287,645	136,137
3	La Marque	Hardin County	1	1	32	553,600	273,000
3	Liberty	Galveston County Memorial	1	1	100	1,298,648	260,000
3	Livingston	Yettie Kersting Memorial	*1	1	45	401,579	194,254
3	Longview	Polk County	*1	1	40	505,843	235,235
		Gregg Memorial	1	5	60	891,777	283,435

3	Longview	Gregg Memorial	1	5	60	891,777	283,435	
2	Lubbock	Lubbock Memorial	1	1	230	3,383,500	500,000	
3	Madisonville	Madison County	1	1	15	149,727	48,576	
3	Marshall	Kahn Memorial	1	2	54	94,451	30,129	
3	Mason	Mason Memorial	1	1	10	105,238	35,079	
2	McAllen	McAllen Municipal	1	5	53	1,014,000	507,000	
3	Midland	Midland Memorial	*1	1	75	1,308,678	432,613	
1	Mission	City Hospital	1	1	40	630,000	310,000	
2	Mount Pleasant	Titus County	1	1	30	398,000	198,000	
3	Nacogdoches	City Memorial	1	1	71	428,553	214,277	
2	New Braunfels	New Braunfels	*1	5	40	563,920	281,960	
3	Palestine	Anderson County	*1	1	84	1,012,280	496,390	
3	Pampa	Highland General	1	1	90	1,093,602	364,534	
3	Port Arthur	Norton Memorial Public Health Center	1	1		131,463	43,821	
3	Port Lavaca	Calhoun County	5	1	20	261,494	86,305	
3	Do	do	1	1		39,542	19,771	
3	Post	Garza County	*1	2	24	400,000	200,000	
3	Robert Lee	Coke County Memorial	1	1	10	113,728	35,173	
3	Rock Springs	Edwards County Memorial	1	1		22,824	7,608	
2	Rusk	Rusk Memorial	1	1		104,850	52,335	
3	Do	do	1	5	9	206,080	64,777	
3	San Angelo	St. John's	1	1	31	214,000	107,000	
1	San Antonio	Santa Rosa Hospital	1	2	25	2,300,000	1,135,000	
1	Do	San Antonio State TB	1	5	99	2,650,000	1,012,500	
2	Do	Robert B. Green Memorial	*2	2	600	2,339,299	1,157,500	
3	Do	Bexar County TB	*1	5	175	341,769	113,923	
3	Do	Grace Lutheran Sanatorium	2	2	100	340,719	49,206	
3	Do	San Augustine City Memorial	*2	2	11	153,665	49,889	
3	San Augustine	Dolly Vinsant Memorial	1	1	20	445,693	144,564	
3	San Benito	San Saba County	1	1	40	168,599	56,200	
3	San Saba	Cogdell Memorial	1	1	20	1,081,000	540,500	
2	Snyder	Scurry County Public Health Center	*1	1	50	88,800	44,400	
2	Do	Lillian M. Gudspeth Memorial	5	1		387,758	155,165	
3	Sonora	Spur Municipal	1	1	25	251,500	125,000	
2	Spur	Memorial Hospital of Martin County	1	1	20	262,344	84,948	
3	Stanton	Sterling County	1	1	20	180,000	90,000	
3	Sterling City	Hopkins County	1	1	15	199,717	61,906	
3	Sulphur Springs	do	1	1	31	88,194	44,097	
3	Do	Terrell State	1	5	17	2,104,327	500,000	
3	Terrell	Throckmorton Memorial	3	4	550	177,000	87,500	
3	Throckmorton	Trinity Memorial	1	1	18	118,196	39,399	
3	Trinity	Swisher County	1	1	14	153,498	51,166	
3	Tulia	Smith County	1	2	14	1,685,457	558,776	
3	Tyler	Uvalde County Memorial	1	1	133	410,420	136,807	
3	Uvalde	Providence	1	1	36	1,438,952	393,206	
3	Waco	do	1	2	100	458,839	204,109	
3	Do	Wichita General	*1	2		1,840,000	920,000	
3	Wichita Falls	Tyler County	1	5	100	207,914	65,117	
3	Woodville	Huth Memorial	1	1	23	121,027	60,514	
3	Yoakum	Yorktown Memorial	1	2	16	433,985	216,993	
3	Yorktown		1	1	20			

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	UTAH						
3	American Fork	American Fork	1	1	29	$372,439	$124,140
3	Monticello	San Juan County	1	3	8	46,128	15,376
3	Nephi	Juab County	1	1	14	297,992	132,964
3	Provo	Utah Valley	1	5	65	582,608	194,202
3	Do	Utah State	*3	2		266,132	94,398
3	Richfield	Sevier County Health Center	5	1		66,071	21,973
2	Salt Lake	Holy Cross	*1	5		1,286,304	578,838
2	Do	St. Marks	1	2	24	492,707	221,682
2	Salt Lake City	Salt Lake County General	1	2	30	675,053	287,534
2	Salt Lake	Child Health Center	*8	1		769,708	247,964
2	St. George	Washington County	1	1	32	488,162	217,423
2	Tooele City	Tooele County	1	1	31	548,710	246,919
3	Vernal	Uintah County	1	1	35	437,336	145,779
	VERMONT						
3	Barre	Barre City	1	2	15	473,826	157,942
3	Brattleboro	Brattleboro Memorial	1	2	10	277,945	92,648
2	Burlington	Mary Fletcher	1	2	158	2,525,455	780,106
2	Do	State Health Laboratory	8	1		413,914	63,914
3	Montpelier	Heaton	1	5	59	746,327	241,666
3	Morrisville	Copley	1	3	25	34,835	10,961
3	St. Albans	Kerbs Memorial	1	1	68	1,224,000	408,000
	VIRGINIA						
3	Abingdon	Johnston Memorial	*1	5	46	783,354	270,781
3	Amherst	Amherst County Public Health Center	5	1		110,190	36,730
2	Arlington	Arlington	1	2	70	497,481	250,233
2	Do	Arlington Public Health Center	5	1		152,000	76,456
1	Bedford	Bedford County Memorial	1	1	43	903,000	298,405
2	Briston Kings	Mountain Memorial	*1	2		412,653	202,182
1	Charlottesville	University of Virginia	*1	5	76	876,700	440,980
2	Do	Martha Jefferson and Sanatorium	*1	5	50	1,105,724	450,185
1	Covington	Alleghany Memorial	*1	2	11	128,000	42,299
3	Cumberland	Cumberland County Public Health Center	5	3		21,869	10,682
2	Danville	The Memorial Hospital	*1	5	105	2,971,000	1,419,040
3	Dinwiddie	Dinwiddie County Public Health Center	5	1		102,935	50,438
3	Emporia	Greensville County Public Health Center	5	1		40,577	19,863
2	Farmville	Southside Community	*1	5	37	660,968	323,459
3	Fredericksburg	Mary Washington Public Health Center	7	1	100	1,647,050	520,372
3	Front Royal	Warren Memorial	*1	1	43	810,027	256,295
3	Harrisonburg	Rockingham Memorial	*1	5	118	1,521,950	502,215
3	Do	Rockingham County Public Health Center	5	1		223,257	109,368
1	Lebanon	Russell County Public Health Center	5	1		60,000	31,980
3	Leesburg	Loudoun County	1	5	19	525,792	173,760
2	Lexington	Stonewall Jackson	1	1	60	1,110,000	558,330
2	Louisa	Louisa County Memorial	7	1	23	292,310	131,565

		Louisa County Memorial	1	1	60	1,110,000	173,760
			7	1	23	292,310	558,330
							131,565

3	Lovingston	Nelson County Public Health Center	5	1		72,580	24,350
1	Lynchburg	Lynchburg	1	1	200	3,501,000	1,156,940
2	Nassawadox	Northampton-Accomack Memorial	*1	5	28	643,050	328,728
3	Do	Northampton Public Health Center	5	1		68,596	30,060
3	Pearisburg	Giles Memorial	1	1	46	835,890	262,333
2	Petersburg	Petersburg General	*1	1	180	3,107,000	1,454,248
1	Portsmouth	Norfolk County Public Health Center	5	1		20,000	10,060
1	Radford	Radford Community	*1	5		23,000	7,601
1	Richmond	Richmond Memorial	1	1	210	5,640,000	1,839,010
1	Do	Retreat for the Sick	*1	2	10	240,000	79,310
3	Do	Medical College of Virginia	*1	2	27	274,872	91,624
3	Do	Richmond Eye	1	1	42	763,000	373,870
3	Do	Richmond Public Health Center	5	1		69,279	33,660
1	Roanoke	Memorial and Crippled Children	*1	5	159	2,887,000	954,038
1	Do	Burrell Memorial	1	1	80	1,696,000	560,460
3	Do	Roanoke Public Health Center	5	1		387,720	189,357
1	Rocky Mount	Franklin Memorial	7	2	14	100,000	44,591
3	Do	do	1	1	40	617,488	301,840
2	South Boston	Halifax Community	1	1	50	925,000	453,250
2	South Hill	Community Memorial	1	1	40	850,000	427,550
3	Staunton	Kings Daughters	*1	1	117	2,496,530	850,905
1	Suffolk	Louise Obici	1	2	24	140,000	46,264
2	Do	Tri-County and Suffolk Public Health Center	5	1		167,160	83,830
3	Do	Louise Obici Memorial	1	1	117	2,222,490	773,027
2	Sussex	Sussex County Public Health Center	5	1		45,000	23,985
2	Winchester	Winchester Memorial	*1	5	111	2,400,000	1,056,000
3	Woodstock	Shenandoah County Memorial	1	1	45	787,801	273,032
	WASHINGTON						
3	Aberdeen	St. Joseph	1	5	72	1,500,138	318,766
3	Bellingham	St. Josephs	1	2	61	676,497	225,499
2	Centralia	Lewis County	*1	2	18	316,927	126,400
1	Chehalis	Lewis County Health Center	5	1		185,400	32,600
3	Do	St. Helen	1	5	42	750,000	300,000
3	Chelan	Lake Chelan	1	1		35,698	11,899
3	Colville	Mount Carmel	1	1	36	744,067	222,666
3	Forks	Olympic Clinic	1	1	13	176,247	58,749
3	Goldendale	Klickitat	1	1	19	289,384	96,126
2	Longview	St. Johns	*1	5	51	1,195,690	476,225
1	Moses Lake	Samaritan	1	1	50	806,000	270,000
3	Odessa	Lincoln County	1	1	9	177,899	59,300
3	Olympia	Thurston Mason Health Center	5	1		309,000	34,720
3	Pasco	Our Lady of Lourdes	1	2	46	610,038	194,308
3	Port Angeles	Olympic Memorial	1	1	76	1,053,551	375,872
3	Pullman	Community Hospital and Clinic	*1	5	3	431,104	144,382
3	Puyallup	Lutheran Minor	4	1		496,681	28,000
3	Ritzville	Adams County	1	4	20	330,379	132,152
1	Seattle	Ballard General	1	1	100	1,780,000	712,000
2	Do	Children's Orthopedic	1	1		5,405,366	64,000
2	Do	University of Washington	*1	1	24	2,844,743	600,000
3	Sedro Woolley	Memorial Hospital	1	5	40	235,083	92,800
2	Southbend	Willapa Harbor Hospital	1	1	39	548,800	158,000
3	Spokane	Sacred Heart	1	5		4,295,556	157,070

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	WASHINGTON—continued						
3	Tacoma	Pierce County Health Center	5	2		$43,613	$14,538
2	Tonasket	St. Martins	1	1	34	576,811	195,124
3	Wenatchee	Central Washington Deaconess	*1	2	50	589,748	165,500
3	White Salmon	Skyline Hospital	1	1	17	242,363	79,044
3	Yakima	Valley Memorial	1	1	157	2,519,353	310,096
	WEST VIRGINIA						
1	Charleston	State Hygienic Laboratory	8	1		512,820	312,821
2	Do	Charleston Memorial	1	1	274	4,566,843	1,522,281
3	Denmar	Denmar Sanitarium	2	2	100	480,000	160,000
3	Do	do	*2	2		67,184	16,000
2	Fairmont	Fairmont General	1	2	55	621,116	385,527
2	Hopemont	Hopemont Sanitarium	2	2	175	1,500,000	500,000
2	Huntington	Huntington State	3	2	156	502,274	167,425
3	Do	do	*3	2	25	152,453	50,818
3	Lakin	Lakin State	*3	2		142,050	42,050
2	Do	do	3	2	42	419,560	139,853
2	Do	Lakin State Hospital	*3	2	40	129,780	43,260
2	New Martinsville	Wetzel County	1	2	33	453,933	244,501
2	Parkersburg	St. Josephs Hospital	*1	2	36	1,262,860	770,345
2	Philippi	Broaddus Hospital Association	1	1	102	1,575,000	960,750
2	Richwood	Sacred Heart	1	1	60	1,471,206	916,414
3	South Charleston	Herbert J. Thomas Memorial	1	3	27	106,251	35,417
2	Spencer	Spencer State	3	2	80	704,591	229,119
3	Do	do	*3	2		121,000	40,333
2	Webster Springs	County Memorial	1	1	31	510,911	317,639
2	Weirton	Weirton	*1	1	134	3,714,000	2,313,451
3	Weston	Weston State	3	2	121	410,351	136,784
	WISCONSIN						
3	Algoma	Algoma Memorial	1	1	30	427,855	190,088
2	Antigo	Langlade County	*1	5	39	1,194,439	511,363
2	Berlin	Berlin Memorial	1	7	35	423,270	190,472
2	Boscobel	Boscobel Memorial	1	4	29	435,798	196,109
3	Burlington	Burlington Memorial	1	2	37	505,611	227,525
3	Clintonville	William Finney Memorial	1	4	50	800,462	262,299
3	Darlington	Lafayette County Memorial	1	1	35	492,064	220,439
3	Dodgeville	St. Josephs	1	2	33	519,339	231,633
3	Durand	St. Benedict Community	1	1	25	620,603	279,271
3	Eau Claire	Lutheran Hospital	1	5	60	801,333	268,382
3	Fort Atkinson	Fort Atkinson Memorial	1	1	62	952,688	313,496
2	Hillsboro	St. Joseph Memorial	1	1	27	575,705	236,117
2	Lacrosse	Lacrosse Lutheran	*1	5	64	1,033,827	408,321
2	Madison	Madison General	1	2	100	2,655,295	483,168
2	Do	State Department of Health Laboratory	8	5		1,693,191	761,936

2	Do	State Department of Health Laboratory	1	8	5	2,655,295	483,168
			2		100	1,693,191	761,936
3	Menomonie	Menomonie Memorial	1	2	33	472,921	142,181
2	Milwaukee	St. Lukes	1	2	153	2,824,188	1,042,159
2	Do	Columbia	1	5	112	1,267,281	143,262
3	New Richmond	Holy Family	1	1	25	439,339	146,446
1	Neillsville	Neillsville	1	1	34	560,000	252,000
3	New London	New London Community	1	5	18	426,421	191,889
2	Oconomowoc	Lutheran Memorial	1	1	50	917,605	412,922
3	Osceola	Osceola General	1	4	10	131,091	58,826
3	Platteville	Platteville Municipal	1	1	30	394,513	129,337
1	Reedsburg	Reedsburg Municipal	*1	2	20	350,000	157,500
2	Rhinelander	St. Marys Hospital	*1	2	67	1,311,304	590,087
3	Rice Lake	St. Josephs	1	2	53	591,112	263,449
2	Richland Center	Richland	1	5	31	483,269	184,402
3	Ripon	Ripon Municipal	1	2	32	439,515	193,250
2	Sheboygan	Sheboygan Memorial	1	2	63	611,470	271,188
1	Spooner	Spooner Community	1	1	20	275,000	123,750
2	Stanley	Victory Memorial	*1	2		28,036	12,616
3	Do	do	1	2	8	139,102	61,920
3	Tomah	Tomah Memorial	1	1	29	423,270	190,471
2	Viroqua	Vernon Memorial	1	2	17	135,372	60,917
3	Do	do	1	1	24	373,976	167,724
3	Waukesha	Waukesha	1	5	60	1,040,830	453,254
3	Winnebago	Winnebago State	3	2	240	2,823,147	913,402
		WYOMING					
3	Buffalo	Johnson County Memorial	1	1	20	268,800	89,067
3	Douglas	Converse County Memorial	1	1	30	302,703	93,797
3	Evanston	Memorial Hospital of Uinta County	1	1	21	259,579	86,527
2	Gillette	Campbell County Memorial	*1	1	32	359,246	119,632
3	New Castle	Weston County Memorial	*1	2	24	192,525	64,175
3	Powell	War Memorial	1	1	31	328,662	107,262
3	Riverton	Fremont County Memorial	1	1	14	255,231	83,670
2	Sheridan	Sheridon County	1	1	90	1,357,124	439,708
3	Torrington	Goshen County Memorial	1	1	46	422,224	129,024
		ALASKA					
3	Fairbanks	St. Josephs	*1	5		1,024,516	47,319
1	Juneau	St. Anns	*1	2	32	500,000	250,000
3	Nome	The Maynard MacDougall	*1	1	34	599,076	198,947
2	Palmer	Valley Presbyterian	1	1	25	535,000	267,000
2	Seward	Seward General	*1	4		328,280	164,140
		HAWAII					
1	Hanapepe	Hanapepe Auxiliary Health Center	6	1		42,000	21,000
3	Hilo	Puumaile TB	*2	1	108	2,409,142	373,157
1	Honolulu	The Queens Hospital	*1	2	102	1,134,600	383,570
2	Do	Kuakini	1	5	119	773,362	386,681
3	Wailuku	Central Maui Memorial	*1	1	140	1,889,521	565,428

Status	Location	Name	Category	Type construction	Beds added	Estimated total cost	Approved Federal share
	PUERTO RICO						
1	Bayamon	Bayamon District	*1	2		$21,000	$14,000
2	Camuy	Camuy Health Center	7	4	22	270,000	180,000
2	Cayey	Cayey Hospital and Health Center	*7	1	42	579,000	386,000
1	Comerio	Comerio Health Center	7	1	22	349,000	226,000
2	Guayama	Guayama Hospital Health Center	*7	5	33	825,000	550,000
2	Hormigueros	Hormigueros Health Center	7	1	12	210,000	140,000
2	Humacao	Humacao Hospital and Health Center	1	1	54	720,000	480,000
2	Isabela	Isabela Health Center	7	1		28,995	19,330
2	Mayaguez	Bella Vista	*1	1	68	507,000	333,333
2	Patillas	Patillas General and Public Health Center	*7	1	22	285,000	190,000
2	Ponce	Ponce Hospital Center	*1	1	416	6,823,634	4,384,013
2	Rincon	Rincon Hospital and Public Health Center	7	1		25,435	16,956
1	Rio Piedras	Rio Piedras TB	2	2		32,643	21,762
2	Do	do	*2	2	800	5,479,423	1,826,474
2	Do	Insular Psychiatric	3	5	704	2,968,049	989,350
2	Do	Insular Psychiatric and TB	*3	2		1,887,000	1,258,000
2	Do	Insular Psychiatric	3	2	758	4,142,395	2,761,597
2	San German	San German Hospital and Health Center	7	1	42	510,000	340,000
1	San Juan	Bayamon	*1	5	28	468,000	312,000
1	Utuado	Utuado Hospital and Health Center	7	1	54	660,000	440,000
2	Vega Baja	Vega Baja Health Center	7	5	26	286,479	190,986
2	Yauco	Yauco Municipal Hospital	*1	2	41	228,369	152,246
	VIRGIN ISLANDS						
3	Char Amalie	Municipal	*1	5		6,299	2,100
3	Christiansted	Department of Health	*5	2		23,646	15,764

TABLE 1.—*Consolidated summary showing status of projects approved under the Public Health Service Act (title VI) as amended, by fiscal year, Dec. 31, 1952*

Status of projects	Number of projects	Estimated cost		Fiscal year	Additions	
		Total cost	Federal share		Hospital beds	Health centers
Total, all projects	1,980	$1,558,312,039	$547,414,688		96,428	[1] 314
	450	284,403,798	74,773,435	1948	21,594	51
	367	276,678,869	74,926,110	1949	18,088	48
	537	445,929,088	149,900,043	1950	27,324	85
	266	240,966,016	84,814,654	1951	12,181	50
	242	199,466,564	78,190,088	1952	10,321	61
	118	110,867,704	50,130,635	1953	6,920	19
			23,929,198	1954		
			10,750,525	1955		
In operation	1,106	600,156,347	209,900,838		42,350	196
	431	256,539,804	67,739,038	1948	18,896	50
	296	174,534,394	53,787,538	1949	11,297	47
	313	148,874,542	62,234,737	1950	10,996	74
	60	16,802,513	17,766,361	1951	1,133	23
	6	3,405,094	7,596,680	1952	28	2
			776,484	1953		
Under construction	713	826,401,000	290,668,123		45,374	89
	19	27,863,994	7,034,397	1948	2,698	1
	71	102,144,475	21,138,572	1949	6,791	1
	224	297,054,546	87,665,306	1950	16,328	11
	206	224,163,503	67,048,293	1951	11,048	27
	167	147,081,252	61,145,099	1952	7,318	44
	26	28,093,230	27,161,514	1953	1,191	5
			13,346,231	1954		
			6,128,711	1955		
Initially approved	161	131,754,692	46,845,727		8,704	29
	69	48,980,218	9,448,309	1952	2,975	15
	92	82,774,474	22,192,637	1953	5,729	14
			10,582,967	1954		
			4,621,814	1955		

[1] Total of 314 for all projects does not include 66 health centers combined with general hospitals.

NOTE.—Final approval of Federal funds from the allotment for fiscal years 1954-55 is deferred pending availability of the allotment.

TABLE 2.—*Number, total cost, and Federal share for projects by State and status of construction, Dec. 31, 1952*

[Funds in thousands of dollars]

Area	All projects			Projects in operation			Projects under construction			Projects initially approved		
	Number	Total cost	Federal share	Number	Total cost	Federal share	Number	Total cost	Federal share	Number	Total cost	Federal share
Total, United States and Territories	1,980	1,558,312	547,415	1,106	600,156	209,901	713	826,401	290,668	161	$131,755	$46,846
Alabama	48	38,685	20,044	29	27,299	12,740	13	8,465	5,396	6	2,922	1,908
Arizona	13	11,709	3,429	7	3,340	1,133	3	7,394	2,018	3	975	278
Arkansas	33	35,480	16,713	26	14,767	6,719	7	20,713	9,993			
California	61	54,233	16,127	32	17,823	5,454	20	29,802	8,665	9	6,608	2,008
Colorado	17	10,419	3,875	10	7,648	2,692	2	993	416	5	1,778	767
Connecticut	18	24,505	3,313	6	2,357	761	12	22,148	2,552			
Delaware	5	4,670	1,400	1	658	228	3	2,204	829	1	1,808	343
District of Columbia	2	5,148	1,341	1	2,433	526	1	2,715	815			
Florida	41	35,553	12,306	21	19,314	6,764	9	10,049	3,448	11	6,189	2,094
Georgia	121	41,704	18,648	75	22,462	9,873	33	15,664	7,551	13	3,578	1,224
Idaho	14	9,115	1,820	13	9,029	1,792	1	86	29			
Illinois	42	59,208	19,205	18	17,902	5,262	21	36,280	11,987	3	5,026	1,956
Indiana	42	35,639	14,194	22	11,681	3,717	19	23,133	10,064	1	825	413
Iowa	45	32,915	9,906	22	11,743	3,837	21	20,077	5,710	2	1,095	359
Kansas	32	20,818	7,099	10	3,398	1,009	20	15,103	5,164	2	2,317	925
Kentucky	76	39,422	20,584	23	12,714	4,861	51	25,428	14,871	2	1,279	853
Louisiana	59	43,238	15,304	26	10,681	3,390	27	27,388	10,101	6	5,169	1,814
Maine	11	7,555	3,753	6	2,224	821	4	4,695	2,582	1	635	349
Maryland	26	20,206	5,503	11	4,784	1,558	11	12,248	2,911	4	3,175	1,034
Massachusetts	49	52,799	11,770	16	12,683	3,514	28	37,593	7,308	5	2,523	948
Michigan	47	43,845	16,353	26	21,637	8,124	14	15,487	5,816	7	6,721	2,413
Minnesota	41	42,321	12,312	29	20,647	6,266	10	20,331	5,446	2	1,343	600
Mississippi	76	36,528	18,562	65	20,551	10,287	9	11,180	6,775	2	4,797	1,500
Missouri	24	30,810	12,918	9	15,132	5,842	15	15,678	7,076			
Montana	18	4,460	1,610	13	2,872	1,006	5	1,589	604			
Nebraska	35	13,713	4,159	12	3,481	772	22	8,982	3,137	1	1,250	250
Nevada	6	1,272	348	2	255	9	4	1,018	339			
New Hampshire	9	7,193	2,241	6	3,981	1,267	3	3,211	975			
New Jersey	30	53,127	13,059	13	14,785	3,492	17	38,342	9,567			
New Mexico	15	10,585	3,861	12	6,255	2,016	3	4,330	1,845			
New York	75	80,026	23,276	51	38,496	12,372	17	27,982	7,587	7	13,548	3,318
North Carolina	128	64,279	22,612	62	26,199	9,082	55	33,524	11,982	11	4,555	1,548
North Dakota	16	4,382	1,581	13	3,381	1,121	3	1,001	460			
Ohio	63	85,300	23,000	21	15,611	4,060	39	60,891	16,648	3	8,798	2,292
Oklahoma	68	26,961	12,393	58	20,763	9,396	5	2,775	1,499	5	3,423	1,497
Oregon	21	16,183	4,373	15	11,999	3,252	5	3,915	1,032	1	268	89
Pennsylvania	60	80,123	28,941	21	24,400	7,800	35	51,556	19,494	4	4,168	1,647

Oregon	21	16,183	4,373	15	11,999	3,252	7	7,955	1,918				
Pennsylvania	60	80,123	28,941	21	24,400	7,800	35	51,556	19,494	4	4,168	1,647	
Rhode Island	9	9,320	2,367	2	1,365	448	7	7,955	1,918				
South Carolina	109	31,696	15,683	100	15,005	6,559	7	16,154	8,855	2	537	289	
South Dakota	15	6,187	1,933	1	299	92	14	5,888	1,841				
Tennessee	49	47,280	16,828	29	22,789	8,542	15	24,166	8,117	5	325	169	
Texas	111	103,270	35,472	78	38,351	14,381	24	52,691	16,151	9	12,228	4,939	
Utah	13	6,329	2,529	7	2,069	729	6	4,261	1,800				
Vermont	7	5,696	1,755	5	2,757	911	2	2,939	844				
Virginia	49	45,937	17,905	21	14,383	5,155	15	15,339	7,239	13	16,215	5,512	
Washington	29	29,136	5,656	20	15,476	3,021	6	10,888	1,620	3	2,771	1,015	
West Virginia	21	19,424	9,305	7	1,479	481	13	17,432	8,511	1	513	313	
Wisconsin	38	29,590	10,944	20	12,815	4,905	15	15,590	5,505	3	1,185	533	
Wyoming	9	3,746	1,218	7	2,030	659	2	1,716	559				
Alaska	5	2,987	927	2	1,624	246	2	863	431	1	500	250	
Hawaii	5	6,249	1,730	2	4,299	939	1	773	387	2	1,177	405	
Puerto Rico	22	27,306	15,212				17	25,776	14,198	5	1,531	1,014	
Virgin Islands	2	30	18	2	30	18							

TABLE 3.—*Additions of hospital beds and health centers by State and Territory, by status of construction, Dec. 31, 1952*

Area	Hospital beds added				Health centers added			
	Total	In operation	Under construction	Initially approved	Total	In operation	Under construction	Initially approved
Total, United States and Territories	96,428	42,350	45,374	8,704	314	196	89	29
Alabama	2,442	1,669	583	190	10	5	2	3
Arizona	909	246	475	188				
Arkansas	2,560	1,428	1,132					
California	2,825	984	1,468	373	11	4	3	4
Colorado	606	454	44	108	3		1	2
Connecticut	643	84	559		2	2		
Delaware	411	40	295	76				
District of Columbia	152	54	98					
Florida	3,021	1,872	683	466	4	2	1	1
Georgia	2,669	1,558	904	207	53	34	13	6
Idaho	708	708						
Illinois	2,980	909	1,814	257	1	1		
Indiana	1,856	776	1,030	50	1	1		
Iowa	2,013	807	1,134	72				
Kansas	1,398	301	910	187				
Kentucky	3,182	902	1,980	300	24		23	1
Louisiana	2,407	882	1,175	350	26	11	15	
Maine	437	168	244	25				
Maryland	1,142	296	658	188	8	3	4	1
Massachusetts	2,374	480	1,635	259	2	1	1	
Michigan	2,677	1,466	769	442				
Minnesota	1,840	1,074	672	94	2	2		
Mississippi	3,053	1,814	859	380	28	28		
Missouri	1,666	760	906		2	1	1	
Montana	384	264	120					
Nebraska	761	172	500	89				
Nevada	149	41	108					
New Hampshire	299	144	155					
New Jersey	3,240	716	2,524					
New Mexico	769	489	280					
New York	4,672	2,432	1,403	837	2	2		
North Carolina	4,644	2,318	2,080	246	26	11	13	2
North Dakota	249	191	58					
Ohio	4,757	779	3,615	363	2		2	
Oklahoma	3,335	2,793	300	242	4	3	1	
Oregon	1,306	983	281	42				
Pennsylvania	3,860	1,364	2,227	269				
Rhode Island	395	86	309					
South Carolina	2,127	1,403	694	30	65	64	1	
South Dakota	414	28	386					
Tennessee	2,446	1,555	877	14	12	5	3	4
Texas	7,471	3,476	2,924	1,071	6	3	2	1
Utah	268	151	117		1	1		
Vermont	335	177	158					
Virginia	2,341	760	754	827	14	9	3	2
Washington	977	661	166	150	3	2		1
West Virginia	1,491	273	1,218					
Wisconsin	1,755	894	787	74				
Wyoming	308	186	122					
Alaska	91	34	25	32				
Hawaii	469	248	119	102	1			1
Puerto Rico	3,144		3,040	104				
Virgin Islands					1	1		

FEDERAL EXPENDITURES FOR COMPLETED PROJECTS

Mr. BUSBEY. The entire amount of $542,500,000 for construction that has already been appropriated is actually allocated to the States, as I understand it.

Dr. CRONIN. That is correct.

Mr. BUSBEY. How much of these funds has actually been expended in payments for buildings that have been completed?

Dr. CRONIN. We will have to furnish that for the record.

(The information referred to is as follows:)

As of February 28, 1953, $370,486,288 has actually been paid out to project sponsors.

FEDERAL AND STATE OBLIGATIONS AND EXPENDITURES, 1948–53

Mr. BUSBEY. Can you furnish for the record a statement showing, by States, the allocation of funds, the total payments to States, the amount of funds that have been firmly obligated by the States, the amount actually expended for completed construction, the unobligated balance, and the unexpended balance?

Dr. CRONIN. Yes.

Mr. BUSBEY. Without objection, we will include that in the record at this point.

(The information requested is as follows:)

Statement showing State allotment, obligations incurred, and corresponding payments under appropriation "Grants for hospital construction, Public Health Service" as of Feb. 28, 1953

FISCAL YEAR 1948

State	Federal share					
	State allocation	Obligations incurred (pt. IV)	Unobligated balance	Obligations incurred (pt. IV)	Liquidations	Unliquidated obligations
Alabama	$2,885,880	$2,871,015	$14,865	$2,871,015	$2,871,015	0
Arizona	451,739	442,935	8,804	442,935	442,935	0
Arkansas	1,966,582	1,966,580	2	1,966,580	1,966,582	−$2
California	1,956,160	1,950,994	5,166	1,950,994	1,950,994	0
Colorado	656,652	656,652	0	656,652	656,652	0
Connecticut	421,523	421,523	0	421,523	421,523	0
Delaware	100,000	100,000	0	100,000	100,000	0
District of Columbia	298,110	298,110	0	298,110	298,110	0
Florida	1,460,260	1,459,419	841	1,459,419	1,459,417	2
Georgia	2,976,228	2,974,241	1,987	2,974,241	2,974,241	0
Idaho	293,162	293,162	0	293,162	293,162	0
Illinois	2,768,690	2,768,690	0	2,768,690	2,768,690	0
Indiana	1,726,355	1,722,935	3,420	1,722,935	1,722,936	−1
Iowa	1,340,446	1,339,501	945	1,339,501	1,330,662	8,839
Kansas	932,719	930,333	2,386	930,333	930,332	1
Kentucky	2,587,095	2,584,722	2,373	2,584,722	2,564,503	20,219
Louisiana	2,154,850	2,151,807	3,043	2,151,807	2,143,341	8,466
Maine	454,438	452,492	1,946	452,492	452,492	0
Maryland	869,663	869,663	0	869,663	869,663	0
Massachusetts	1,593,795	1,588,336	5,459	1,588,336	1,538,783	49,553
Michigan	2,169,996	2,169,996	0	2,169,996	2,169,996	0
Minnesota	1,656,926	1,646,982	6,944	1,646,982	1,646,982	0
Mississippi	2,401,451	2,399,814	1,637	2,399,814	2,360,068	39,746
Missouri	2,280,213	2,188,514	91,699	2,188,514	2,147,903	40,611
Montana	231,530	231,529	1	231,529	231,530	−1
Nebraska	684,394	670,517	13,877	670,517	656,505	14,012
Nevada						
New Hampshire	342,122	342,122	0	342,122	342,122	0
New Jersey	1,312,554	1,312,554	0	1,312,554	1,312,554	0
New Mexico	457,062	457,063	−1	457,063	457,062	1
New York	2,941,663	2,940,541	1,122	2,940,541	2,850,886	89,655
North Carolina	3,429,016	3,428,071	945	3,428,071	3,426,493	1,578
North Dakota	308,157	303,795	4,362	303,795	303,795	0
Ohio	2,690,189	2,686,198	3,991	2,686,198	2,611,210	74,988
Oklahoma	1,639,006	1,632,066	6,940	1,632,066	1,632,068	−2
Oregon	460,361	460,048	313	460,048	460,048	0
Pennsylvania	4,547,379	4,528,264	19,115	4,528,264	4,440,970	87,294
Rhode Island	279,966	279,704	262	279,704	279,704	0
South Carolina	1,974,755	1,973,809	946	1,973,809	1,962,544	11,265
South Dakota	359,217	355,445	3,772	355,445	355,445	0
Tennessee	2,671,070	2,671,070	0	2,671,070	2,671,070	0
Texas	4,836,567	4,828,222	8,345	4,828,222	4,828,221	1
Utah	364,840	363,293	1,547	363,293	363,292	1
Vermont	214,510	214,510	0	214,510	214,510	0
Virginia	2,208,159	2,208,158	1	2,208,158	2,208,159	−1
Washington	511,646	508,158	3,488	508,158	508,157	1
West Virginia	1,554,281	1,554,281	0	1,554,281	1,053,354	500,927
Wisconsin	1,621,161	1,621,160	1	1,621,160	1,621,161	−1

Statement showing State allotment, obligations incurred, and corresponding payments under appropriation "Grants for hospital construction, Public Health Service" as of Feb. 28, 1953—Continued

FISCAL YEAR 1948—Continued

State	Federal share					
	State allocation	Obligations incurred (pt. IV)	Unobligated balance	Obligations incurred (pt. IV)	Liquidations	Unliquidated obligations
Wyoming	$144,856	$144,856	0	$144,856	$144,856	0
Alaska	100,000	99,846	$154	99,846	99,846	0
Hawaii	222,758	222,758	0	222,758	222,758	0
Puerto Rico	2,460,083	2,460,083	0	2,460,083	2,356,269	$103,814
Virgin Islands	32,765	2,100	30,665	2,100	2,100	0
Total	75,000,000	74,748,637	251,363	74,748,637	73,697,671	1,050,966

FISCAL YEAR 1949

Alabama	$2,690,543	$2,689,254	$1,289	$2,689,254	$2,689,252	$2
Arizona	443,109	440,805	2,304	440,805	440,805	0
Arkansas	1,966,552	1,966,552	0	1,966,552	1,966,552	0
California	2,121,367	2,107,813	13,554	2,107,813	2,107,699	114
Colorado	635,878	635,878	0	635,878	635,878	0
Connecticut	422,222	422,222	0	422,222	414,420	7,802
Deleware	100,000	100,000	0	100,000	100,000	0
District of Columbia	275,268	275,268	0	275,268	194,796	80,472
Florida	1,481,446	1,481,446	0	1,481,446	1,481,446	0
Georgia	2,791,307	2,791,054	253	2,791,054	2,786,580	4,474
Idaho	300,347	300,347	0	300,347	300,347	0
Illinois	2,764,357	2,755,779	8,578	2,755,779	2,699,916	55,863
Indiana	1,754,093	1,753,127	966	1,753,127	1,750,033	3,094
Iowa	1,393,932	1,393,932	0	1,393,932	1,377,765	16,167
Kansas	972,758	972,496	262	972,496	972,497	−1
Kentucky	2,560,957	2,554,012	6,945	2,554,012	2,529,688	24,324
Louisiana	2,099,507	2,099,506	1	2,099,506	1,962,895	136,611
Maine	467,139	464,903	2,236	464,903	464,903	0
Maryland	827,301	827,300	1	827,300	809,572	17,728
Massachusetts	1,622,561	1,622,355	206	1,622,355	1,600,714	21,641
Michigan	2,174,668	2,174,668	0	2,174,668	2,174,668	0
Minnesota	1,725,122	1,722,282	2,840	1,722,282	1,701,968	20,314
Mississippi	2,270,043	2,264,474	5,569	2,264,474	2,256,282	8,192
Missouri	2,293,924	2,293,925	−1	2,293,925	2,240,114	53,811
Montana	224,137	224,137	0	224,137	224,137	0
Nebraska	682,443	681,781	662	681,781	652,359	29,422
Nevada	100,000	100,000	0	100,000	100,000	0
New Hampshire	367,648	367,648	0	367,648	367,648	0
New Jersey	1,328,053	1,328,053	0	1,328,053	1,151,669	176,384
New Mexico	457,632	457,632	0	457,632	457,632	0
New York	3,029,743	3,029,381	362	3,029,381	2,881,850	147,531
North Carolina	3,413,486	3,413,484	2	3,413,484	3,380,190	33,294
North Dakota	287,845	286,182	1,663	286,182	278,940	7,242
Ohio	2,715,846	2,715,099	747	2,715,099	2,594,518	120,581
Oklahoma	1,730,437	1,730,438	−1	1,730,438	1,730,437	1
Oregon	534,815	533,692	1,123	533,692	533,692	0
Pennsylvania	4,692,355	4,692,355	0	4,692,355	4,459,693	232,662
Rhode Island	267,856	267,856	0	267,856	267,856	0
South Carolina	1,923,581	1,923,581	0	1,923,581	1,922,737	844
South Dakota	353,873	353,873	0	353,873	349,837	4,036
Tennessee	2,616,055	2,616,055	0	2,616,055	2,576,093	39,962
Texas	4,865,137	4,863,829	1,308	4,863,829	4,820,134	43,695
Utah	354,023	354,023	0	354,023	354,023	0
Vermont	227,131	227,131	0	227,131	227,131	0
Virginia	2,114,928	2,111,962	2,966	2,111,962	2,111,962	0
Washington	553,979	553,978	1	553,978	553,979	−1
West Virginia	1,529,058	1,529,059	−1	1,529,059	1,264,864	264,195
Wisconsin	1,610,133	1,608,172	1,961	1,608,172	1,608,173	−1
Wyoming	146,879	146,879	0	146,879	146,879	0
Alaska	100,000	99,101	899	99,101	99,101	0
Hawaii	261,868	251,304	10,564	251,304	251,304	0
Puerto Rico	2,327,387	2,327,387	0	2,327,387	674,222	1,653,165
Virgin Islands	29,271	15,764	13,507	15,764	15,764	0
Total	75,000,000	74,919,234	80,766	74,919,234	71,715,614	3,203,620

Statement showing State allotment, obligations incurred, and corresponding payments under appropriation "Grants for hospital construction, Public Health Service" as of Feb. 28, 1953—Continued

FISCAL YEAR 1950

State	Federal share					
	State allocation	Obligations incurred (pt. IV)	Unobligated balance	Commitments incurred (pt. I or IV)	Liquidations	Unliquidated obligations
Alabama	$5,140,275	$5,138,154	$2,121	$5,138,154	$5,138,155	−$1
Arizona	852,521	852,521	0	852,521	852,521	0
Arkansas	3,776,391	3,776,392	−1	3,776,392	3,776,391	1
California	5,147,909	5,143,952	3,957	5,143,952	4,476,998	666,954
Colorado	1,022,875	1,022,874	1	1,022,874	1,008,970	13,904
Connecticut	1,016,289	1,016,289	0	1,016,289	920,169	96,120
Delaware	200,000	200,000	0	200,000	200,000	0
District of Columbia	490,555	490,555	0	490,555	490,555	0
Florida	2,895,128	2,895,128	0	2,895,128	2,895,128	0
Georgia	5,248,356	5,242,360	5,996	5,242,360	5,163,898	78,462
Idaho	627,378	627,379	−1	627,379	627,378	1
Illinois	4,723,670	4,721,672	1,998	4,721,672	3,513,153	1,208,519
Indiana	3,838,365	3,837,757	608	3,837,757	3,392,233	445,524
Iowa	3,051,411	3,051,286	125	3,051,286	2,860,286	191,000
Kansas	2,044,104	2,044,079	25	2,044,079	1,962,600	81,479
Kentucky	4,933,095	4,933,095	0	4,933,095	4,305,251	627,844
Louisiana	4,239,701	4,239,699	2	4,239,699	3,683,151	556,548
Maine	1,069,132	1,069,133	−1	1,069,133	1,069,132	1
Maryland	1,585,285	1,585,285	0	1,585,285	1,397,196	188,089
Massachusetts	3,312,332	3,307,991	4,341	3,307,991	3,234,362	73,629
Michigan	5,134,736	5,134,737	−1	5,134,737	5,112,950	21,787
Minnesota	3,414,126	3,414,126	0	3,414,126	3,258,925	155,201
Mississippi	4,469,485	4,469,485	0	4,469,485	4,453,794	15,691
Missouri	4,340,297	4,340,296	1	4,340,296	3,965,267	375,029
Montana	345,499	345,499	0	345,499	343,255	2,244
Nebraska	1,367,926	1,367,897	29	1,367,897	1,141,224	226,673
Nevada	200,000	200,000	0	200,000	149,124	50,876
New Hampshire	636,060	636,061	−1	636,061	636,060	1
New Jersey	2,923,571	2,923,571	0	2,923,571	2,923,571	0
New Mexico	812,552	812,551	1	812,551	812,552	−1
New York	5,942,049	5,942,049	0	5,942,049	5,583,288	358,761
North Carolina	6,414,042	6,414,042	0	6,414,042	6,081,646	332,396
North Dakota	473,041	473,041	0	473,041	439,092	33,949
Ohio	5,979,473	5,976,418	3,055	5,976,418	5,403,235	573,183
Oklahoma	3,683,879	3,683,878	1	3,683,878	3,683,879	−1
Oregon	1,544,418	1,530,788	13,630	1,530,788	1,505,787	25,001
Pennsylvania	9,241,058	9,241,057	1	9,241,057	8,117,644	1,123,413
Rhode Island	522,590	522,590	0	522,590	522,590	0
South Carolina	3,693,309	3,693,276	33	3,693,276	3,496,945	196,331
South Dakota	585,912	585,912	0	585,912	436,241	149,671
Tennessee	4,977,256	4,977,255	1	4,977,255	4,568,203	409,052
Texas	9,494,344	9,492,245	2,099	9,492,245	9,047,557	444,688
Utah	754,320	754,320	0	754,320	722,640	31,680
Vermont	421,695	421,044	651	421,044	421,045	−1
Virginia	4,062,611	4,061,293	1,318	4,061,293	3,651,062	410,231
Washington	1,834,829	1,831,137	3,692	1,831,137	1,794,896	36,241
West Virginia	2,787,048	2,787,049	−1	2,787,049	1,762,337	1,024,712
Wisconsin	3,105,901	3,105,900	1	3,105,900	3,082,394	23,506
Wyoming	245,652	245,652	0	245,652	245,652	0
Alaska	200,000	200,000	0	200,000	158,749	41,251
Hawaii	500,884	500,884	0	500,884	495,035	5,849
Puerto Rico	4,619,631	4,619,631	0	4,619,631	1,140,190	3,479,441
Virgin Islands	57,034	0	57,034	0	0	0
Total	150,000,000	149,899,285	100,715	149,899,285	136,124,356	13,774,929

FISCAL YEAR 1951

Alabama	$2,901,596	$2,901,597	−$1	$2,901,597	$2,901,596	$1
Arizona	481,233	481,233	0	481,233	481,233	0
Arkansas	2,131,707	2,131,706	1	2,131,706	2,106,989	24,717
California	2,905,905	2,905,906	−1	2,905,906	1,045,582	1,860,324
Colorado	577,395	577,396	−1	577,396	508,414	68,982
Connecticut	573,677	573,678	−1	573,678	439,516	134,162
Delaware	200,000	200,000	0	200,000	200,000	0
District of Columbia	276,910	276,910	0	276,910	207,306	69,604
Florida	1,634,249	1,634,248	1	1,634,248	1,634,249	−1
Georgia	2,962,605	2,962,605	0	2,962,605	1,818,735	1,143,870
Idaho	354,144	354,144	0	354,144	353,157	987
Illinois	2,666,429	2,666,429	0	2,666,429	1,895,435	770,994
Indiana	2,166,690	2,166,689	1	2,166,689	1,253,980	912,709

Statement showing State allotment, obligations incurred, and corresponding payments under appropriation "Grants for hospital construction, Public Health Service" as of Feb. 28, 1953—Continued

FISCAL YEAR 1951—Continued

State	Federal share					
	State allocation	Obligations incurred (pt. IV)	Unobligated balance	Commitments incurred (pt. I or IV)	Liquidations	Unliquidated obligations
Iowa	$1,722,468	$1,722,468	0	$1,722,468	$969,178	$753,290
Kansas	1,153,861	1,153,861	0	1,153,861	519,065	634,796
Kentucky	2,784,646	2,784,493	$153	2,784,493	1,708,039	1,076,454
Louisiana	2,393,237	2,393,237	0	2,393,237	1,735,326	657,911
Maine	603,506	603,506	0	603,506	603,506	0
Maryland	894,866	894,866	0	894,866	870,076	24,790
Massachusetts	1,869,754	1,869,753	1	1,869,753	1,050,408	819,345
Michigan	2,898,469	2,898,468	1	2,898,468	2,373,661	524,807
Minnesota	1,927,214	1,927,213	1	1,927,213	969,799	957,414
Mississippi	2,522,946	2,522,948	−2	2,522,948	2,139,380	383,568
Missouri	2,450,022	2,450,021	1	2,450,021	830,343	1,619,678
Montana	200,000	200,000	0	200,000	189,059	10,941
Nebraska	772,170	772,171	−1	772,171	565,280	206,891
Nevada	200,000	48,407	151,593	48,407	20,718	27,689
New Hampshire	359,048	359,048	0	359,048	359,048	0
New Jersey	1,650,305	1,650,304	1	1,650,304	1,578,452	71,852
New Mexico	458,671	458,671	0	458,671	458,671	0
New York	3,354,183	3,354,182	1	3,354,182	2,602,336	751,846
North Carolina	3,620,615	3,620,615	0	3,620,615	2,764,141	856,474
North Dakota	267,023	267,022	1	267,022	161,227	105,795
Ohio	3,375,308	3,375,308	0	3,375,308	2,294,204	1,081,104
Oklahoma	2,079,485	2,079,486	−1	2,079,486	2,073,559	5,927
Oregon	871,797	870,402	1,395	870,402	699,598	170,804
Pennsylvania	5,216,416	5,216,415	1	5,216,415	2,654,996	2,561,419
Rhode Island	294,993	294,993	0	294,993	294,993	0
South Carolina	2,084,809	2,084,805	4	2,084,805	1,802,546	282,259
South Dakota	330,737	330,738	−1	330,738	291,563	39,175
Tennessee	2,809,574	2,809,573	1	2,809,573	1,391,065	1,418,508
Texas	5,359,392	5,359,391	1	5,359,391	4,547,492	811,899
Utah	425,801	425,801	0	425,801	425,801	0
Vermont	238,039	238,039	0	238,039	238,039	0
Virginia	2,293,273	2,293,273	0	2,293,273	1,598,800	694,473
Washington	1,035,729	1,035,143	586	1,035,143	363,234	671,909
West Virginia	1,573,240	1,573,239	1	1,573,239	1,027,137	546,102
Wisconsin	1,753,227	1,753,226	1	1,753,226	1,439,206	314,020
Wyoming	200,000	200,000	0	200,000	180,115	19,885
Alaska	200,000	200,000	0	200,000	0	200,000
Hawaii	282,740	282,740	0	282,740	282,740	0
Puerto Rico	2,607,701	2,607,700	1	2,607,700	315,398	2,292,302
Virgin Islands	32,195	0	32,195	0	0	0
Total	85,000,000	84,814,067	185,933	84,814,067	59,234,391	25,579,676

FISCAL YEAR 1952

Alabama	$3,014,588	$3,007,459	$7,129	$3,007,458	$2,401,004	$606,454
Arizona	483,702	483,702	0	483,702	67,267	416,435
Arkansas	1,885,430	1,870,888	14,542	1,870,888	1,196,399	674,489
California	2,758,014	2,754,973	3,041	2,120,943	48,154	2,072,789
Colorado	581,476	568,285	13,191	466,793	98,331	368,462
Connecticut	621,996	534,277	87,719	534,278	257,427	276,851
Delaware	200,000	200,000	0	200,000	196,000	4,000
District of Columbia	204,735	2,750	201,985	0	0	0
Florida	1,893,140	1,846,942	46,198	1,744,898	1,391,765	353,133
Georgia	3,068,889	3,032,403	36,486	3,027,005	1,166,789	1,860,216
Idaho	324,984	245,299	79,685	245,299	241,727	3,572
Illinois	2,695,593	2,695,593	0	2,250,364	985,096	1,265,268
Indiana	2,034,798	2,000,746	34,052	1,906,996	1,121,075	785,921
Iowa	1,346,525	1,312,245	34,280	1,312,244	350,309	961,935
Kansas	1,081,829	1,072,438	9,391	1,072,438	149,050	923,388
Kentucky	2,685,339	2,371,213	314,126	2,371,414	1,030,013	1,341,401
Louisiana	2,251,098	2,248,377	2,721	1,546,375	485,533	1,060,842
Maine	621,258	621,258	0	621,258	621,258	0
Maryland	1,020,721	976,142	44,579	476,142	172,755	303,387
Massachusetts	2,061,948	1,677,986	383,962	1,551,731	448,426	1,103,305
Michigan	2,662,947	2,794,366	−131,419	1,551,591	279,409	1,272,182
Minnesota	1,674,461	1,648,706	25,755	1,648,706	278,572	1,370,134
Mississippi	2,404,732	2,403,945	787	2,403,946	408,565	1,995,381
Missouri	2,186,873	2,107,731	79,142	2,107,731	0	2,107,731
Montana	207,113	203,611	3,502	203,611	104,449	99,162
Nebraska	668,669	658,667	10,002	408,666	8,391	400,275
Nevada	200,000	200,000	0	49	49	0

Statement showing State allotment, obligations incurred, and corresponding payments under appropriation "Grants for hospital construction, Public Health Service" as of Feb. 28, 1953—Continued

FISCAL YEAR 1952—Continued

State	Federal share					
	State allocation	Obligations incurred (pt. IV)	Unobligated balance	Commitments incurred (pt. I or IV)	Liquidations	Unliquidated obligations
New Hampshire	$324,081	$324,081	0	$324,081	$254,278	$69,803
New Jersey	1,694,722	1,686,392	$8,330	1,686,391	1,435,240	251,151
New Mexico	539,397	539,397	0	539,397	531,525	7,872
New York	3,575,887	3,575,887	0	3,525,887	646,915	2,878,972
North Carolina	3,715,001	3,714,365	636	3,714,365	968,802	2,745,563
North Dakota	264,285	250,890	13,395	250,889	154,558	96,331
Ohio	3,292,080	3,212,082	79,998	2,812,080	641,208	2,170,872
Oklahoma	1,708,338	1,647,553	60,785	1,647,551	1,292,631	354,920
Oregon	577,949	577,950	−1	577,949	298,784	279,165
Pennsylvania	4,711,853	4,203,144	508,709	3,769,145	572,337	3,196,808
Rhode Island	357,383	357,383	0	357,383	337,540	19,843
South Carolina	2,080,814	2,005,689	75,125	1,781,274	894,396	886,878
South Dakota	315,141	307,089	8,052	307,089	263,487	43,602
Tennessee	2,954,710	2,772,344	182,366	2,715,145	822,135	1,893,010
Texas	5,011,244	4,891,297	119,947	4,344,521	1,302,104	3,042,417
Utah	415,457	403,594	11,863	403,594	81,299	322,295
Vermont	259,609	259,609	0	259,609	259,609	0
Virginia	2,446,564	2,458,867	−12,303	2,166,872	447,217	1,719,655
Washington	1,020,065	1,002,337	17,728	657,737	211,185	446,552
West Virginia	1,524,191	1,524,192	−1	1,483,754	13,837	1,469,917
Wisconsin	1,703,089	1,702,815	274	1,702,815	255,508	1,447,307
Wyoming	200,000	190,817	9,183	190,817	18,774	172,043
Alaska	200,000	128,459	71,541	78,459	0	78,459
Hawaii	249,930	249,930	0	88,580	44,380	44,200
Puerto Rico	2,487,331	2,416,911	70,420	1,376,910	4,224	1,372,686
Virgin Islands	30,021	0	30,021	0	0	0
Total	82,500,000	79,943,076	2,556,924	71,896,820	25,259,786	46,637,03

FISCAL YEAR 1953

Alabama	$2,674,162	$2,670,728	$3,434	$1,457,727	$124,762	$1,332,965
Arizona	463,728	451,728	12,000	173,283	0	173,283
Arkansas	1,685,566	1,650,000	35,566	1,650,000	228,351	1,421,649
California	2,565,659	2,260,565	305,094	0	0	0
Colorado	539,688	355,481	184,207	8,070	0	8,070
Connecticut	564,189	344,835	219,354	225,000	19,274	205,726
Delaware	200,000	200,000	0	200,000	142,380	57,620
District of Columbia	200,000	0	200,000	0	0	0
Florida	1,806,581	1,640,093	166,488	987,592	575,629	411,963
Georgia	2,774,251	2,373,190	401,061	412,277	0	412,277
Idaho	291,180	0	291,180	0	0	0
Illinois	2,438,910	2,430,250	8,660	1,733,539	0	1,733,539
Indiana	1,865,636	1,625,129	240,507	1,437,629	559,569	878,060
Iowa	1,205,231	1,088,402	116,829	945,696	0	945,696
Kansas	989,639	696,307	293,332	146,072	0	146,072
Kentucky	2,379,780	2,016,514	363,266	1,863,418	134,801	1,728,617
Louisiana	2,066,930	1,702,332	364,598	1,547,332	43,695	1,503,637
Maine	541,997	541,586	411	192,336	192,336	0
Maryland	950,170	349,687	600,483	247,152	2,935	244,217
Massachusetts	1,859,157	1,540,412	318,745	1,031,658	88,025	943,633
Michigan	2,444,644	1,184,810	1,259,834	9,960	0	9,960
Minnesota	1,502,369	1,502,369	0	1,340,108	126,100	1,214,008
Mississippi	2,161,135	2,151,722	9,413	2,149,722	0	2,149,722
Missouri	1,997,746	142,374	1,855,372	142,374	0	142,374
Montana	200,000	188,841	11,159	188,841	79,154	109,687
Nebraska	607,828	10,009	597,819	10,009	0	10,009
Nevada	200,000	200,000	0	0	0	0
New Hampshire	289,988	265,906	24,082	265,906	0	265,906
New Jersey	1,557,402	1,557,403	−1	1,557,402	604,009	953,393
New Mexico	521,666	478,209	43,457	478,209	478,209	0
New York	3,237,309	2,807,779	429,530	800,594	22,969	777,625
North Carolina	3,379,249	2,525,818	853,431	850,483	10,512	839,971
North Dakota	230,635	0	230,635	0	0	0
Ohio	2,985,375	2,765,137	220,238	2,003,164	227,574	1,775,590
Oklahoma	1,548,466	1,080,252	468,214	170,252	36,717	133,535
Oregon	528,592	527,123	1,469	310,583	0	310,583
Pennsylvania	4,234,841	1,697,000	2,537,841	786,000	0	786,000
Rhode Island	319,776	319,776	0	284,446	276,802	7,644
South Carolina	1,865,785	1,437,765	428,020	1,119,265	0	1,119,265
South Dakota	279,264	0	279,264	0	0	0
Tennessee	2,661,875	975,940	1,685,935	689,940	0	689,940

Statement showing State allotment, obligations incurred, and corresponding payments under appropriation "Grants for hospital construction, Public Health Service" as of Feb. 28, 1953—Continued

FISCAL YEAR 1953—Continued

State	Federal share					
	State allocation	Obligations incurred (pt. IV)	Unobligated balance	Commitments incurred (pt. I or IV)	Liquidations	Unliquidated obligations
Texas	$4,640,780	$2,785,000	$1,855,780	$710,000	$260,000	$450,000
Utah	381,661	228,499	153,162	228,499	1,246	227,253
Vermont	229,146	229,146	0	229,146	219,420	9,726
Virginia	2,230,318	2,070,782	159,536	0	0	0
Washington	929,243	759,000	170,243	89,000	0	89,000
West Virginia	1,355,066	352,218	1,002,848	64,584	0	64,584
Wisconsin	1,540,051	1,174,180	365,871	640,930	0	640,930
Wyoming	200,000	200,000	0	200,000	0	200,000
Alaska	200,000	200,000	0	0	0	0
Hawaii	222,220	222,220	0	0	0	0
Puerto Rico	2,228,307	1,504,573	723,734	288,000	0	288,000
Virgin Islands	26,809	0	26,809	0	0	0
Total	75,000,000	55,481,090	19,518,910	29,866,198	4,454,469	25,411,729

Mr. BUSBEY. Did you indicate in your prepared statement the number of additional hospital beds that have resulted from construction completed to date under this program?

Dr. CRONIN. Ninety-six thousand five hundred has been the number of beds represented by the approved projects under this program. There are about three hundred and some-odd health centers and some other projects such as State health laboratories, and so on.

UNEXPENDED FUNDS FOR HOSPITAL SURVEY AND PLANNING

Mr. BUSBEY. How much of the fund for the hospital survey is now allocated to the States but unspent by them?

Dr. CRONIN. There has been $1,800,000 allocated to the States. They have received in cash $1,455,080.23 leaving a balance to be available to be given to the States of $344,919.77.

Mr. BUSBEY. Of the funds given to the States, is there a balance that is unspent?

Dr. CRONIN. The balances left in the States: 27 States have no money left, and 25 States have a balance of $344,919.77.

Mr. BUSBEY. Why do these 25 States and Puerto Rico have this balance to their credit that they have not spent?

Dr. CRONIN. Partly because they have not raised their activity of surveying to the extent they would spend the money if they got it, and partly, they have not asked for the money. Some of these States in the 25 group are States that have State agency staffs which are so small that they cannot serve the States.

Mr. BUSBEY. Do you mean that they are getting more money than they can spend?

Dr. CRONIN. No. This is the original allocation which was given to the States when the law was first passed, and the States matched the allocation 2 to 1. Now, some of the State agencies have not taken on a survey activity staff with reference to this program.

Mr. BUSBEY. What happens to these funds if they do not take on this survey activity?

Dr. CRONIN. At the present time they remain where they are. We requested several years ago that these funds be made available for redistribution to other States, but we have been unable to legislatively acquire that privilege. We think that it would be a good thing to do.

Mr. BUSBEY. Without objection, the table will be inserted in the record at this point.

(The table referred to is as follows:)

Statement showing, by States, balances of survey and planning funds under appropriation 75X0368 "Payments to States for surveys and programs for hospital construction, PHS" as of Feb. 28, 1953

Total appropriation available	$1,800,000.00
Total payment as of Feb. 28, 1953	1,455,080.23
Appropriation balance	344,919.77

STATES WITH NO BALANCES	Amount
1. Arizona	0
2. California	0
3. Colorado	0
4. Florida	0
5. Georgia	0
6. Idaho	0
7. Indiana	0
8. Kentucky	0
9. Louisiana	0
10. Maryland	0
11. Massachusetts	0
12. Minnesota	0
13. Mississippi	0
14. Montana	0
15. Nevada	0
16. New Jersey	0
17. New York	0
18. North Carolina	0
19. North Dakota	0
20. Oregon	0
21. South Carolina	0
22. Utah	0
23. Virginia	0
24. Washington	0
25. West Virginia	0
26. Alaska	0
27. Hawaii	0

STATES WITH BALANCES	Amount
1. Alabama	$16,300.00
2. Arkansas	4,182.00
3. Connecticut	7,321.88
4. Delaware	10,000.00
5. District of Columbia	11,220.00
6. Illinois	24,703.50
7. Iowa	801.00
8. Kansas	168.16
9. Maine	3,730.00
10. Michigan	23,382.00
11. Missouri	36,103.05
12. Nebraska	54.24
13. New Hampshire	436.80
14. New Mexico	1,209.99
15. Ohio	30,194.04
16. Oklahoma	1,856.21
17. Pennsylvania	98,875.02
18. Rhode Island	3,500.00
19. South Dakota	2,245.37
20. Tennessee	11,913.00
21. Texas	36,382.31
22. Vermont	2,500.00
23. Wisconsin	4,105.00
24. Wyoming	7,613.93
25. Puerto Rico	6,122.27
	344,919.77

ESTIMATED COST OF OVERCOMING NATIONAL HOSPITAL BED DEFICIENCY

Mr. BUSBEY. In the paragraph at the top of page 5 of your prepared statement, you say:

> Even when one takes into consideration the existence of about 117,000 Federal hospital beds serving the civilian population such as those administered by the Veterans' Administration, the Indian Service and the Public Health Service, our national bed deficiency still remains 733,000.

Taking into consideration the increased annual needs, what do you estimate would be the cost of meeting the deficiency?

Dr. CRONIN. I would like to break that down into 2 groupings; 1, the defiicency created in the country by 2 factors that we cannot escape. Those are the factors of annual population increase, and the second factor of obsolescent-attrition in our hospital plants. The

population increase last year was approximately 2,600,000. I prefer to use 2 million as the annual population increase. If we have the annual population increase continue, such as we have had, of 2 million per year, and the need in the hospital service area to the people of the country is approximately 12 beds per 1,000 people, we would need 24,000 beds to be constructed just because we lived through New Year's Eve.

Now, No. 2. To that should be added the number of beds which would be required to meet the attrition brought about, or the loss brought about, by obsolescence. I would like to state that the hospital plant of our country is 40 percent currently over 40 years of age. We feel that the life expectancy of the hospital is about 50 years. From such other factors over which we have no control, a man cannot control adequately such things as fire, flood, rain, earthquakes and hurricanes, and to point that out I might say that last August, due to the earthquake in Kern County, Calif., and Bakersfield, 500 of their 600 hospital beds were destroyed. From that sort of factors, and the normal factors of obsolescence, it is anticipated that the average loss in this country for general hospitals alone, not mental, tuberculosis, and chronic, is about $100 million a year. Figuring the beds now cost on an average of $16,000 a bed, we then will have $16,000 divided into the $100 million, or a little bit more than 6,000 beds a year lost through that source. Adding that 6,000 loss to the 24,000 loss brought about by population increase, we would be faced, and are faced, with a 30,000-bed need on those 2 factors alone.

In answer to your question, What will we have to have to offset that loss? If we use the figure of $16,000 per bed, and multiply the 30,000 beds, we would need a hospital construction program in the country amounting to $480 million this coming year, from all sources, Federal or non-Federal aid.

Now, the Hill-Burton program currently is building one-third of all hospital construction in the country. Two-thirds of it is being built without Federal aid. It would be proper to assume, then, I think, that one-third of the $480 million needed to construct hospitals to offset those two factors would be the Hill-Burton area of sharing. That would be $160 million.

The Federal share in the Hill-Burton program is currently 47 percent. The State and local community share is 53 percent. If we reduce that for mathematic convenience to a 50–50 program, 50 percent of the $160 million would be $80 million, which would be the amount of money that the Hill-Burton program would expect to receive from the Federal appropriation. And currently our request is for $75 million, which means that our request, if granted in its total, would still be $5 million short, and that would be matched by $5 million of State and local money, or a total of $10 million short of meeting the two factors of population increase and obsolescence rate without any reduction whatsoever in the accumulated deficit of over 850,000 beds.

Mr. BUSBEY. The overall program for the 850,000 beds would cost how much money, roughly?

Dr. CRONIN. Well, it costs $16,000 a bed to build a hospital, and if we multiply $16,000 by 850,000 that will be a figure of $13,600,000,000 that would be required to build all the beds needed in this country at this time. I think that is the reason when we first started this pro-

gram, then the bed deficit estimated by the Commission on Hospital Care was around 900,000, that the law was set up on the basis that Congress would each year appropriate a sum of money. We would have been able if circumstances prevailed today that existed in 1947 when the law was passed—we did not have inflation to the extent we have it today; we did not have the Korean incident taking place; we were not in the international situation that we are currently in—we would have been able to cut down somewhat the accumulated deficit.

ADEQUACY OF PRESENT PROGRAM

But at the present time the program is meeting the need only for population increase and obsolescence without any reduction in the accumulated deficit that has piled up over the last 20 years.

OCCUPANCY RATIO

Mr. BUSBEY. Now on page 5 of the prepared statement you state:

> In terms of percentages, in 1948, 41 percent of our general hospital bed needs were unmet. This was reduced to less than 33 percent in 1952. However, two-thirds of our national bed deficit is accounted for by the need to provide beds for patients with mental and long-term illnesses. As we begin to more nearly satisfy the needs for general hospital beds, increasing emphasis must be given to the needs in the other bed categories; that is, tuberculosis, mental, and chronic.

How many of the beds provided under this program are not being utilized to help this situation because of the low occupancy ratio?

Dr. CRONIN. That, Mr. Chairman, I would have to look up because we do not know. We have not been able to carry on those kinds of studies. Furthermore, I think it is only right to point out since this law provides under section 635 that the Federal Government shall not in any way have anything to do with the operation of these hospitals, or the selection of personnel to staff these hospitals, or the administration of the hospitals, that in the administration of this program we have been very careful to have the Federal Government not get into matters that would in any way look like we were getting into the operational picture. As a result, such matters as beds not occupied, or the occupancy rate, are strictly operational matters, and the Federal Government has not attempted to get into that situation whatsoever. I think that we could have come fairly close to it if we had gotten the money to do the studies relating to the research necessary for this program, but that has not been granted to us.

Mr. BUSBEY. We have been talking about the deficiency of beds. Let us look at the other side for just a moment. If the State has more beds in one area than the formula provides, is the excess disregarded in calculating the deficiency?

Dr. CRONIN. Mr. Chairman, the formula that is used by the States is a ceiling that is set, beyond which the Hill-Burton program will not be made available. If an area in the State has more beds than it needs, according to that ceiling, the Hill-Burton money will not be available in that particular area.

APPROPRIATIONS RELATED TO UNMET BED NEEDS

Mr. FOGARTY. Dr. Cronin, as I understood one of your last statements, it was to the effect that because of 2 factors, the increase in population of 2 million a year, and the obsolescence of existing hospitals from year to year, the existing beds are insufficient and therefore, in order to insure adequacy of facilities, we would have to appropriate about $80 million a year under this act.

Dr. CRONIN. That is correct.

Mr. FOGARTY. That would not cut into the existing backlog of need for additional beds these surveys indicate.

Dr. CRONIN. We would not reduce that accumulated deficit at all.

Mr. FOGARTY. Now, this law was enacted in 1947?

Dr. CRONIN. 1946; August of 1946.

Mr. FOGARTY. That was for a 5-year program?

Dr. CRONIN. That is correct.

Mr. FOGARTY. It was extended when?

Dr. CRONIN. October 25, 1949, until June 30, 1955.

Mr. FOGARTY. So this act as of now only runs for 1 additional fiscal year?

Dr. CRONIN. That is correct; June 30, 1955.

PENDING LEGISLATION

Mr. FOGARTY. I understand that bills have been introduced in the Senate and the House to extend this act another 5 years; is that right?

Dr. CRONIN. That is correct; Senator Taft, of Ohio, and Senator Hill, of Alabama, have introduced the act in the Senate to extend the program until June 30, 1960, and Representative Oren Harris, of Arkansas, has introduced an identical bill.

Mr. FOGARTY. They do not contemplate a change in the formula or the basic act, do they? They would just extend the date for 5 years?

Dr. CRONIN. It is a very short bill. In fact, it is a one-word bill that replaced the word "five" with the word "ten." The end result is that the program is extended as it is until June 30, 1960, if this bill is passed.

SIZE OF AUTHORIZATION AND APPROPRIATION

Mr. FOGARTY. That means that it still would carry an authorization of $150 million a year?

Dr. CRONIN. It would still carry that authorization.

Mr. FOGARTY. The act authorizes the appropriation of $150 million, and we have been appropriating only one-half of what Congress previously authorized, or $75 million?

Dr. CRONIN. That is correct.

Mr. FOGARTY. In other years the Senate has sometimes seen fit to raise this appropriation. A couple of years ago it increased the amount to something over $80 million, did it not?

Dr. CRONIN. That is correct. It raised it from $75 million, which was the House-approved amount, to $82.5 million, and the House went along with that and the appropriation came out as $82.5 million.

EFFECT OF REDUCTION IN APPROPRIATION

Mr. FOGARTY. What effect would it have on this program if this $75 million were reduced, let us say, by 10 percent, or $7½ million?

Dr. CRONIN. Well, the net effect in the final analysis would be a reduction in the number of beds that were built. However, because of the fact that 31 of the States in their operational planning have adopted the so-called split technique——

SPLIT TECHNIQUE OF FINANCING PROJECTS

Mr. FOGARTY. What is "split technique"?

Dr. CRONIN. That is for a large project requiring, let us say, $3 million of Federal money. If the Federal percentage were one-third, the community would have a large expenditure. If the total project cost $9 million, the Federal share would be $3 million, or one-third; and the State allotment in any 1 year would be in the neighborhood of $1 million. It is obvious that that State could not build that particular project in 1 year, so the split-project technique is one that permits the State to advise the project sponsors that in 1 fiscal year they will give them a certain amount, in the next fiscal year they will give them a certain amount, and in the next fiscal year they will give them a certain amount. That would be splitting the project over a 3-year period.

In the 2 future years, of course, it is provisional upon Congress appropriating the money for that purpose which the sponsor recognizes.

Basically the States really never know how much money they are going to get because the program is at the $150 million authorization level and has been programed all the way from $75 million to $85 million. Then they are able to proceed in their planning to let these bigger projects be split. Some of the smaller ones are split.

If this program were reduced at all below $75 million, say by $1 million, I think about 4 States would have problems, because they have projects under construction that would have to stop and be refinanced with somebody else coming up with the money, rather than the Federal Government, which they have coming to them. If it went below $1 million, down to 10 percent, or about $7½ million, I think we would have about 5 or 6 States in trouble.

Mr. FOGARTY. What would happen if it were reduced by $15 million?

Dr. CRONIN. If it went down $15 million we would have approximately 7 or 8 States in trouble.

RHODE ISLAND

Mr. FOGARTY. How would it affect my State of Rhode Island? We have some split projects in Rhode Island. What would happen if there were a reduction in this appropriation?

Dr. CRONIN. There are four projects in the State of Rhode Island which would be adversely affected.

Mr. FOGARTY. What are they?

Dr. CRONIN. Those projects are located at Pawtucket, the Memorial Hospital; at Cranston, the Osteopathic General; at Providence, the Miriam Hospital; and at Providence, the Roger Williams General Hospital.

If this program were reduced, as you asked, by the $15 million, which would be your 20-percent reduction, the 1954 allotment to Rhode Island, on the basis of $75 million, is $310,923. If the program were reduced 20 percent, which is $60 million, Rhode Island would only receive $247,602.

Now, Rhode Island has these 4 projects, indicated money to them available in the amount of $319,776, so a reduction down to the $60 million, which is your question, would mean that Rhode Island would be in the hole to the tune of $72,174 on these 4 projects.

The Memorial Hospital would be cut from $5,000; the Osteopathic General, at Cranston, would be cut from $55,000; the Miriam Hospital, Providence, from $126,601; and the Roger Williams General, Providence, from $133,175.

Those four projects would have to seek those respective cut sums of money from sources other than the Federal Government if this program is reduced. That is brought about because the formula of giving the money to the States is a set thing. Any reduction in the program appropriation is going to affect every State.

ANTICIPATED RATE OF APPLICATIONS FOR PROJECT ASSISTANCE

Mr. FOGARTY. Do you know anything about the rate of applications from the States? How many projects are there in the country which could be approved or could be built with the help of these funds if the law were continued?

Dr. CRONIN. In anticipation, Mr. Fogarty, when the bill was introduced by Senator Taft, Senator Hill, and Mr. Harris, we tried to find out what was the anticipated desire of the people of the country in the respective States for building hospitals utilizing Hill-Burton money. This analysis we felt was an indication, perhaps, of how they would feel about a continuation of the program. We were asked for that information.

The summary of the anticipated hospital construction, contingent upon extension of the Hill-Burton Act, indicated that there would be a total from all the people representing projects who wanted to build of $1,253,070,000 worth of hospitals that could go ahead. That would require under the existing Hill-Burton Act a Federal share of $467,735,000.

Now, I think that gives us a fairly good indication that the people of the country are interested in building hospitals to the extent that they are willing to come up with $800 million some to match the $467 million that the Federal Government would put in.

Mr. FOGARTY. If this act is not extended, no doubt many of these projects will not be built.

Dr. CRONIN. I think there is no question about that, because these projects first represent people who are willing to accept Federal aid in the construction of hospitals because they cannot get them built any other way. Undoubtedly some of them may go ahead, but my guess would be that very few of them would go ahead without assistance. They would not be able to.

Mr. FOGARTY. There is not any doubt that the hospitals which have been planned or built under the Hill-Burton funds are attracting physicians into the rural areas; is there?

Dr. CRONIN. Mr. Fogarty, there is no doubt at all in my mind. We can take statements—and have from various States—indicating that doctors are going into these smaller areas; that if it had not been for the Hill-Burton program I am sure they would not have had the hospitals built.

Mr. FOGARTY. I remember our discussion a few years ago, when some people claimed that there was a shortage of doctors in the country, and another group claimed there was no shortage, but that the question was trying to get the doctors to go out into the areas where there was a shortage. It seems to me that no one had an answer to that problem a few years ago, until something like this came along. Now it is happening, is it not? They are going into these areas where they have the facilities to use in their practice.

Dr. CRONIN. That is correct. And, Mr. Fogarty, in the March issue of Hospitals magazine there is an article written by Mr. Foster and Mr. Lesparre, employees of the American Hospital Association. This association is very much interested and has been in this hospital program, since its inception, and has worked very cooperatively with the Representatives in the House and the Senators in the Senate, in devising what kind of program this should be, back in the early days of the Commission on Hospital Care.

The American Hospital Association has surveyed four States on its own, without any assistance from any Federal authority, or even our knowledge, in fact, until after it was done, as objectively as possible, to see just what was this Hill-Burton program doing. The article indicates that the Hill-Burton hospitals are not having any more trouble than any other hospital is having throughout the country with regard to staffing of their hospitals with various types of health personnel; and, furthermore, that there have been attracted to the areas that did not have professional services of physicians, and again nurses, and other individuals in those health professions to serve the people of these communities, because these modern hospitals have been developed; and where the doctor could practice medicine as he was taught to practice it and not be under the handicap of lack of instruments of precision.

Mr. FOGARTY. That was my understanding of that argument, that there was a sufficient number of doctors but that there was no way anyone could get them to go into a small town or rural area where suitable facilities just did not exist. But this program in large degree provided such facilities. That, I think, is one of the most important things in the whole program.

Dr. CRONIN. That is correct, Mr. Fogarty.

Mr. FOGARTY. Spreading the available medical men around the country.

Dr. CRONIN. There is one other thing in that regard which I think it is worth while pointing out. Again, it was pointed out in the article in Hospitals that the Hill-Burton program has acted as a catalyzer for the building of hospitals outside of the Hill-Burton program and even without Federal aid. A great number of hospitals have been

built because, for the first time, due to the Hill-Burton program and the thinking that was put into that program, there is an orderly system of building hospitals in the country, and people have been, you might say, alerted to the fact of the great shortage that they have and that there are ways of getting things done. Many of these communities have gone ahead without Hill-Burton aid.

One of the values, so to speak, I think, of the Hill-Burton program, which has been demonstrated, is that it does demonstrate to those people who can and wish to build a hospital without Federal aid, that they can do so; but to those people who financially are so set upon, so to speak, that they could not do it without Federal aid, there is the opportunity given to do it.

Mr. FOGARTY. That is all, Mr. Chairman.

Mr. BUSBEY. The committee will recess until 2 o'clock

AFTERNOON SESSION

SPLIT PROJECT TECHNIQUE

Mr. BUSBEY. The committee will come to order.

Dr. Cronin, just before we recessed this morning you and Mr. Fogarty, who was chairman of the committee for 4 years, were talking about this split project technique in handling grants for hospital construction. Now, where a project obligation has been spread out over 3 years, say, the sponsors do not have the Federal money coming to them unless the Congress appropriates it; is that right?

Dr. CRONIN. That is correct.

Mr. BUSBEY. They have been properly cautioned that there is no guaranty the Congress will do that, I presume?

Dr. CRONIN. Mr. Chairman, when they sign the application for a project, incorporated in the application form is a statement that the money for years subsequent to the year in which the project is approved, the Federal money coming to them, is provisional upon the Federal Government appropriating the money to the State so that it can in turn allocate the money to them.

ADVANTAGES

Mr. BUSBEY. What is the advantage to the various States of a split payment program?

Dr. CRONIN. Mr. Chairman, the policy establishing the split project technique was developed primarily for two reasons. One is in connection with the approval of a relatively large project, the Federal share of which would take up a great deal of the State's allotment for any one year, or would exceed the State's allotment for a particular fiscal year; and the other reason is that it would permit a State agency to split the Federal financial participation in particular projects over successive fiscal year allotments in order to initiate more construction within the State and answer the need for hospital construction more broadly, as the need was quite broad in the State.

Mr. BUSBEY. In other words, the split payment arrangement permits them to get more hospitals started than they would under the other method?

Dr. CRONIN. That is possible and true. I think the other thing is also true: That a big project in a State that receives a relatively small

allotment of Federal money makes it possible for that big project to get under way in that State, which it could not do because of the size of the State's allotment under the Hill-Burton program. In fact, splitting a project is about the only practical way that a large project in terms of size could get built without the State and sponsors waiting a number of years.

The other thing I think we must remember is that the State funds, the funds available to the States, are only good for 2 years. Some of these big university projects, for instance, will take all of that and longer to build, because of their size.

Mr. BUSBEY. Well, the number of large projects throughout the United States is comparatively small compared to the number of projects in the rural communities.

Dr. CRONIN. Projects numberswise; yes, sir. Not dollarwise, though, in the program.

LARGE PROJECTS

Mr. BUSBEY. Where are these large hospitals built, for the most part?

Dr. CRONIN. They are built in practically every State in the Union, on the large projects. Thirty-one States are splitting projects. Several examples of this would be the University of Arkansas Medical School Hospital, the University of Mississippi Medical School Hospital, the University of South Carolina Medical School Hospital, the University of Nebraska Medical School Hospital psychiatric unit, and the University of Minnesota has a unit under this program.

Mr. BUSBEY. Would you furnish for the record, at this point, the total amount of money, by States, being allocated to split projects for fiscal years 1954 and 1955?

Dr. CRONIN. Yes, sir.

(The information is as follows:)

Statement showing amounts of construction applications split over ensuing fiscal years under appropriation "Grants for hospital construction, PHS" as of Feb. 28, 1953

FISCAL YEARS 1954–55

State	Total	1954	1955
Alabama	$782,625	$782,625	
Arizona	275,877	275,877	
Arkansas	3,346,136	1,646,136	$1,700,000
California			
Colorado	126,286	126,286	
Connecticut			
Delaware	400,000	200,000	200,000
District of Columbia			
Florida	1,428,750	1,293,750	135,000
Georgia	2,746,293	2,212,923	533,370
Idaho			
Illinois	1,164,390	1,164,390	
Indiana	1,087,551	1,087,551	
Iowa			
Kansas	249,765	249,765	
Kentucky	2,527,869	2,066,514	461,355
Louisiana	469,120	364,120	105,000
Maine			
Maryland			
Massachusetts	380,491	380,491	
Michigan			
Minnesota	437,456	437,456	
Mississippi	2,349,067	1,461,067	888,000
Missouri			
Montana	215,389	185,000	30,389
Nebraska			
Nevada	53,843	53,843	

Statement showing amounts of construction applications split over ensuing fiscal years under appropriation "Grants for hospital construction, PHS" as of Feb. 28, 1953—Continued

FISCAL YEARS 1954-55—Continued

State	Total	1954	1955
New Hampshire			
New Jersey	$2,600,946	$1,538,606	$1,062,340
New Mexico	657,483	345,568	311,915
New York	3,699,907	2,487,833	1,212,074
North Carolina			
North Dakota			
Ohio	3,975,901	2,486,176	1,489,725
Oklahoma	1,246,106	947,385	298,721
Oregon			
Pennsylvania	720,171	720,171	
Rhode Island	324,526	319,776	4,750
South Carolina	2,886,481	1,800,000	1,086,481
South Dakota			
Tennessee	179,823	179,823	
Texas	4,220,000	1,906,250	2,313,750
Utah			
Vermont	165,758	165,758	
Virginia	2,835,602	1,727,288	1,108,314
Washington	280,415	280,415	
West Virginia			
Wisconsin			
Wyoming	89,708	89,708	
Alaska			
Hawaii			
Puerto Rico			
Virgin Islands			
Total	41,923,735	28,982,551	12,941,184

STATE OF ILLINOIS

Mr. BUSBEY. I notice that under the split project program my home State of Illinois carries $1,164,390 in 1954, but nothing in 1955. Why?

Dr. CRONIN. It may be that the State of Illinois did not have any projects that were split out into that year. This is all at the discretion of the State. The Illinois State agency may have decided: "We do not want to split anything into 1955." Although some States have, Mr. Chairman, split all the way to the legislative termination date of the current program, which is June 30, 1955. The State of New Mexico is one of those States. In Illinois the total splitting chargeable to fiscal year 1954 is $1,164,390. That is for 1954.

Mr. BUSBEY. There must have been a figure for 1953, then.

Dr. CRONIN. No, it is the correct figure. In 1953, on the basis of a $75 million total appropriation, the State of Illinois receives $2,385,007. If the appropriation this year were $75 million the State of Illinois would receive $2,385,007, of which $1,164,390 represents the money that would go into the split projects.

RHODE ISLAND

Mr. BUSBEY. Referring to Rhode Island, which was discussed by Mr. Fogarty, I see by the table that it has a total of $324,529 split mostly in 1954, but there will also be a carryover to 1955 of $4,750.

Dr. CRONIN. That is correct.

Mr. BUSBEY. How does this relate to your remark about splitting the money over 3 years in these States?

Dr. CRONIN. There is an example here in Rhode Island. They split it over 2 years, sir. That is all they can split at the present time, due to legislative authority ending June 30, 1955. The project that gets under way on July 2, coming up this year, could be split this year and next year under the program, but a project that got under way a year ago could be split over 3 years.

Mr. HARLOW. Could it be, Dr. Cronin, that the table does not show how much of the 1953 allotment can be for split projects?

Dr. CRONIN. It does not.

Mr. BUSBEY. There is nothing in this table that shows such information for 1953.

Dr. CRONIN. That is correct.

Mr. HARLOW. That is probably the trouble, Mr. Chairman. The table you have does not show how much of the 1953 money is going into split projects.

Dr. CRONIN. That is correct.

Mr. BUSBEY. Well, it may be that the States are not taking too much of a risk, but at the same time, technically speaking, they are taking something of a risk on the funds being appropriated when they go into split projects.

Dr. CRONIN. I would say that the State's risk, that they are taking, is definitely a calculated one, because each project sponsor has a full knowledge of it. When the State agency and a project sponsor sign the application for funds they are fully cognizant of the situation that funds in succeeding or subsequent fiscal years are contingent upon the Congress approving those funds.

I think that part of the reason for this situation is that the authorization under the law is for $150 million, whereas the appropriation each year by Congress has run from $75 million to some years $85 million; one year, $150 million; another year, $82.5 million; and last year, $75 million.

APPROPRIATIONS COMPARED TO AUTHORIZATION

Mr. BUSBEY. This authorization of $150 million a year is in effect a ceiling above which the Congress is not permitted to appropriate.

Dr. CRONIN. That is correct.

Mr. BUSBEY. Although except for 1 year, Congress has never reached that authorization.

Dr. CRONIN. Yes, sir. In 1950 they did appropriate $150 million. In fact, Mr. Chairman, in 1951 the Congress appropriated $150 million, but under the Omnibus Appropriation Act in section 1214 they advised the President to find $550 million in savings, and the reduction in the program took place when the President put in reserve $75 million of the $150 million that the Congress appropriated.

VARIATIONS IN COSTS PER BED

Mr. BUSBEY. I notice at the top of page 6 of your prepared statement that you say:

> It is pertinent to indicate the extent to which an appropriation in fiscal year 1954 can assist the Nation. The average cost per hospital bed today is $16,000.

What are the extremes? In other words, what is the minimum cost and what is the maximum cost per hospital bed?

Dr. CRONIN. Well, it will vary, Mr. Chairman, with the labor market in any one respective State or area, and then with the material costs in those areas. We operate on the basis of compiling figures, when we make this statement, that cover the lowest bid cost in the Nation as against the highest bid cost in the Nation under the Hill-Burton program. That cost is influenced, of course, by various factors such as the cost of building a hospital with a diagnostic X-ray unit in it, and the cost of building a hospital with a therapeutic X-ray unit and a diagnostic unit in it. That will vary the bed cost.

Mr. BUSBEY. In what State have you had the lowest cost?

Dr. CRONIN. We can find that out for you, sir. My guess would be that it is one of the Southern States, maybe North Carolina.

Mr. BUSBEY. If you will, please furnish that for the record.

(The information is as follows:)

ARKANSAS

The sum of $6,633 per bed represents the lowest national cost for complete general hospital projects. This extremely low cost is an isolated instance. More typical of project cost, however, is the middle two-thirds of any range of project costs. The middle two-thirds range from $10,500 to $17,000 per bed.

Mr. BUSBEY. In what State have you had the highest cost?

Dr. CRONIN. I would have to look that up. I do not know offhand. Are you referring to the cost per project?

Mr. BUSBEY. Per bed.

Dr. CRONIN. The cost per project or the average cost in the State?

Mr. BUSBEY. I am talking about individual projects.

Dr. CRONIN. Individual projects.

Mr. BUSBEY. Which projects have cost the most money per bed?

Dr. CRONIN. Would you have reference, Mr. Chairman, to a complete project, a new project, or an addition to an existing hospital? The cost is more to add to an existing hospital, per bed, than it would cost you to build a completely new hospital, because on the additions, if you have a 100-bed hospital and you add 50 beds as an addition, the cost per bed of the 50-bed addition will encompass the cost of going into the old hospital and adding several boilers for heating in the new unit, or it may even require the tearing out of the wiring in the older part of the hospital, so that you can get in the heavier-gage wire, because you will have the load going through that wire to take care of the new unit.

(The information is as follows:)

CALIFORNIA

The sum of $38,842 per bed represents the highest national cost for complete general hospital projects. This extremely high cost is an isolated instance. However, Federal participation was limited to necessary cost of construction, adjusting per bed cost to $28,374.

COMPARISON OF COSTS OF NEW CONSTRUCTION AND OF ADDING TO EXISTING FACILITIES

Mr. BUSBEY. What is the advantage, then, in adding to an old hospital, in preference to building a new hospital?

Dr. CRONIN. Well, it is not a question of the advantage so much as it is a question of what can the community do and what do they want to do? Many communities can raise sufficient money to build 14 or

15 beds, which they can add onto an existing structure of 50 beds, rather than to build a completely new 50-bed hospital, because that would be beyond their resources.

By and large in the program if circumstances are such we feel it is better to build a new unit then it is to add onto old units. When you get to the older parts of the country—for example, the New England area—where the hospitals have been in existence for many, many years, most of our projects are not new hospitals but are additions to older existing hospitals.

AGE OF HOSPITALS

Mr. BUSBEY. In your testimony this morning you used an age figure of 40 years. Was that for a certain group of hospitals?

Dr. CRONIN. Yes; 40 percent of all the hospitals in the country are over 40 years of age.

Mr. BUSBEY. And the estimated life expectancy is 50 years?

Dr. CRONIN. We anticipate that under normal building with today's materials and so on we could expect a life expectancy of about 50 years.

Mr. BUSBEY. Some of these older hospitals still look to me as if they are in pretty good condition.

Dr. CRONIN. Some of those older hospitals are excellent hospitals in terms of building construction. However, many have wooden floor joists and wooden floors. As we learn more about fire prevention and that type of thing, those hospitals more and more are being replaced with metal, which is more fire resistive than wood, and those hospitals are more and more being subjected to scrutiny as hazardous places in which to put people than had been true in the past.

Mr. BUSBEY. It seems to me that it would be worth while to consider leaving these old hospitals as overflow or emergency hospitals and to build a new unit in the community. I imagine that the hospitals in New England you referred to have a great number of years behind them.

Dr. CRONIN. Mr. Chairman, that decision does not rest with the Federal Government but rests with the State agency administering the program in the State. The State agency decides on what they want to do with the help of their advisory council in the State, in regard to the program in the State to be carried out.

FEDERAL JURISDICTION OVER PROJECT APPROVAL

Mr. BUSBEY. Do you not have any jurisdiction over a proposal of the State if, in your judgment, it does not seem economically sound?

Dr. CRONIN. If the project sponsors in a particular area of the State meet in their proposal the minimum requirements set forth in the law, then the Federal Government is in the position of approving that project. Now, the minimum requirements in the law are of such a character that they would enable each of these projects to be a project worthy of getting assistance. They are not maximum requirements; they are minimum.

Mr. BUSBEY. Even if a State wanted to build a hospital that will cost, say, $75,000 a bed, it could go ahead and build it with Hill-Burton funds?

Dr. CRONIN. No; we would definitely advise the State that we thought the costs per bed were exorbitant and we would not approve that project.

Mr. BUSBEY. Then you do have some authority over the projects to which Federal money is allocated?

Dr. CRONIN. We have the authority to scrutinize and advise the States and to not participate. On the other hand, the responsibility for coming up with the project is not the Federal Government's responsibility; it is that of the State and the local community.

Mr. BUSBEY. Let us say, for instance, that the State wants to build a $75,000 cost-per-bed hospital, you advise the State against it and its officials say: "Well, we are going ahead and build it anyway."

Dr. CRONIN. We would say: "You will have to do it without Hill-Burton money." We would not approve the project.

REMODELING OF BUTLER COUNTY MEMORIAL HOSPITAL

Mr. BUSBEY. The other day a situation was called to my attention by the chairman of our full committee, Mr. Taber, regarding the project in Butler County, Pa. He asked me to explore that situation today.

What happened with respect to the remodeling of that hospital? Give us the early history of it. Let us follow it through from the beginning.

Dr. CRONIN. Mr. Chairman, I will confine my remarks to the Butler County Memorial Hospital.

The original Pennsylvania State plan in 1948 delineated very large, unrealistic hospital-service areas. Thus, Butler County was included with Armstrong County in one area, designated as R–2, with a bed need shown as 425, based on 2½ beds per thousand population, which is really used for a rural area. It was also unrealistic to designate an area of 164,570 population as "rural." Priority for this area was established as C.

Between 1948 and 1950 the State plan was completely revised and the large areas were broken up into more realistic hospital-service areas. Thus, Butler County was designated as a single area, I–7, with a population of 94,483. On the basis of 4 beds per thousand, the ratio applicable to intermediate areas, as differentiated from the rural areas, the need was shown to be 378 beds, and the area rated a B priority. It met all of the criteria for an intermediate area—at least 25,000 population and a hospital of 100 beds or more. The Butler County Hospital had 166 beds. Thus the Butler County area had a B priority and the Butler County Hospital was shown in the State plans to have run an occupancy rate from 88 to 96 percent annually. This is substantially higher than the optimum for a hospital of this size.

Under the Hill-Burton program the Federal authorities do not dictate to communities relative to the hospital that should be built. In this case the community desired to remodel the existing hospital and construct 96 new beds and a nurses' home. Possibly an entirely new hospital of 100 beds and a nurses' home would have been cheaper; still the fact remains that this is a Federal, State, and local program and much of its success lies in the fact that the wishes of the local people are recognized and carried out insofar as it is practicable to do so and under the provisions of the law.

In addition, if it is thought that it might have been better to construct a new facility, we can only speculate on whether the State could have interested another project sponsor in the area. Also pointed out is the fact that the larger facility is more conducive to better patient care and a wider range of services than two small facilities.

Part 1 of this project, of October 4, 1950, showed that the Federal share was to be $840,000 and the sponsor's share was to be $1,260, 000, for a total of $2,100,000.

Part 2 of the project, which is the financial-status aspect, showed the sponsor's share to be $1,260,193.48. These are estimated shares. We cannot quite get to the exact figure until the project is really under way or completed. The estimated sponsor's share was $1,260,193.48.

On June 5, 1951, the part 2 was revised and the sponsor's share was shown as $2,076,775.40. This indicated a revision of the total cost estimate to the $3 million range, and the Federal share was 40 percent and the local share was 60 percent.

Now, on February 21, 1951, part 3 was signed, which was a statement that they had clear title to the property, that the substrata geologically was of such an order that it would stand the weight of the hospital.

Part 4 was signed shortly after that, June 5, 1951, and the bids were in, showing the Federal share was $1,383,533.75. The sponsor's share was $2,075,330.63. That is a total cost of $3,458,884.38.

The change orders have decreased this project. As a project gets under construction and as they build, it is common practice that from the estimate of the project in the beginning there will be changes, and as this project went ahead there were change orders which took place.

In November of 1951 a change order occurred, and part 4 was revised which showed that the Federal share was reduced, it then being $1,319,555.75. The sponsor's share was also reduced and is $1,979,-330.63. That is a total of $3,298,884.38.

COST OF BEDS ADDED

This project in total was for the extensive remodeling of the existing facility, including surgical facilities, obstetrical facilities, and kitchen facilities. There was the addition of 96 beds and a nurses' home of 62 beds. The total cost was $3.3 million.

The estimated cost of the nurses' home was $600,000, leaving the project at $2.7 million. The minimum estimate concerning the remodeling, that our engineers and architects can supply me, was $900,000, so that the project then showed $1.8 million as the cost represented in regard to the 96-bed addition.

In other words, out of this total project of $3.3 million, $600,000 went for the building of the nurses' home and $900,000 went for the remodeling of the institution, and $1.8 million went to build a 96-bed addition. This would be a cost of less than $19,000 per bed, when one analyzes this to find out what the beds cost.

Since there has been a loss of 36 beds in the existing building as a result of the remodeling, the net gain in beds was 60.

Mr. BUSBEY. Did not the Public Health Service make a survey of this hospital in 1949 and find that only 35 of the existing 265 beds were unacceptable?

Dr. CRONIN. No, sir; not that I know of.

Mr. BUSBEY. Were all of the beds in the hospital acceptable as it originally stood?

Dr. CRONIN. Yes; the 166 beds, according to the report from the State agency to us.

Mr. BUSBEY. There were how many beds in the original hospital?

Dr. CRONIN. One hundred and sixty-six.

Mr. BUSBEY. You added how many beds to the hospital?

Dr. CRONIN. Ninety-six.

Mr. BUSBEY. Making a total of 262 beds?

Dr. CRONIN. Mr. Chairman, when they remodeled the old hospital to get new delivery rooms for obstetrical cases and to get additional surgical facilities to be utilized by the addition of 96 beds, the space that these new facilities were placed in previously had part of the 166 beds in it, so that there was a loss of 36 beds.

Mr. BUSBEY. Operating rooms and other equipment items are taken into consideration in determining the overall cost per bed in the construction of new hospitals, are they not?

Dr. CRONIN. They are taken into consideration in the cost per bed, but if the facility is a structure to which an addition is being added, the total facility in the final analysis cannot be regarded as the cost per bed or as reflecting the cost per bed when you are adding additional surgical facilities and additional obstetrical facilities needed to supply services to an existing 166 beds.

The net result on this hospital, Mr. Chairman, was a gain of 60 beds, so that the hospital finally came down to 226 beds in the final analysis.

Mr. BUSBEY. What did you say was the total amount of money spent by Federal, State, and local interests, excluding the 60-bed nurses' home?

Dr. CRONIN. $2.7 million.

REMODELING VERSUS NEW CONSTRUCTION

Mr. BUSBEY. Therefore, for $2.7 million, at an average cost of $16,000 per bed, you could have built a new, completely modern 170-bed hospital.

Dr. CRONIN. You could, Mr. Chairman, if that were what the project was outlined to do. However, this project includes more than that. This project included not only the building of additional beds but it included the furnishing of surgical and obstetrical facilities to service the existing beds that were there in a more usable fashion than the ones they had. It included modernization of their obstetrical and surgical facilities. That is why I said that $900,000 is the estimate of the cost of remodeling the building in order to make these other beds more readily usable.

Mr. BUSBEY. I just cannot conceive of spending all of this money on an old hospital when you could have accomplished so much more, it seems to me, if you had disregarded the old structure entirely and built a new hospital. Outside of the new addition you still have an old hospital in some respects.

Dr. CRONIN. I think, Mr. Chairman, we can't speculate as to whether the State could have interested another project sponsor in the area. The Butler County Hospital people were willing to go ahead and build onto their hospital; and to build onto their hospital the program was outlined as it was carried through. If that had not taken place and somebody else in the area had wanted to build a hospital they could have built for $2.7 million a 170-bed hospital. However, the Butler County Hospital was there. This hospital is part of the community, sir, and it is a tradition in their town. The people supporting that hospital wanted to add onto that hospital, and that is what they did; and in our opinion they came out with a bed cost of about $19,000 a bed, when one takes into consideration that it does cost money to remodel these older hospitals to make them acceptable and modern under present-day conventional hospital standards.

Mr. BUSBEY. Well, that is one way to look at it. But it doesn't look quite that way to me.

Dr. CRONIN. All I can say, Mr. Chairman, as administrator of this program, is that we have very carefully not dictated to the States or communities. It is their responsibility and their hospital.

Mr. BUSBEY. What did your agency do to call their attention to what could have been done with respect to building a new hospital?

Dr. CRONIN. They were advised through the State agency, which has the first contact with them and the only contact, because the Federal Government does not contact sponsors.

Mr. BUSBEY. What did your agency do to point this out to the State agency?

Dr. CRONIN. It was pointed out to the State agency that this type of project could be complied with. However, our advice was that communities of this kind would be better off building brand new hospitals. The State agencies told us in return that they did not want to build a brand new hospital, they wanted to remodel what they had. They wanted to know: "Is it eligible under the law?" And the answer is: "Yes, it is eligible."

EXTENSION OF LEGISLATION AND OTHER AMENDMENTS

Mr. BUSBEY. There was some mention of a bill introduced in the House by Congressman Harris, of Arkansas, and in the Senate by Senator Hill and Senator Taft, to extend this law for 5 years. Have you been called on to make any suggestions as to appropriate changes in the law, based upon your experience in administering it since 1946?

Dr. CRONIN. Mr. Chairman, Senator Taft and Senator Hill introduced the Senate bill, which is Senate 967, and Representative Oren Harris of Arkansas introduced the identical bill in the House, H. R. 3171, and as we have pointed out, the bills as presented did not call for any change in the law whatsoever, but an extension of the program for the 5-year period to June 30, 1960. We have not been contacted by anybody in Congress at the present time for our opinion in terms of should the present law be amended.

However, as you know, when the bill that is introduced is referred to the committee, the committee chairman refers the bill down to the Federal agency, which in this instance would be the Federal Security Agency Administrator, for her opinion concerning the bill

that has been introduced. That answer is in the process of being sent back to the chairman of the two committees in the House and Senate. We have not been asked for any amendments by anybody in the Congress as yet.

Mr. BUSBEY. Did you make any suggestions to the Administrator as to what might be put into the law if it is extended to improve it?

Dr. CRONIN. We confined our remarks, Mr. Chairman, to the bill as written.

Mr. BUSBEY. Does the Agency ever initiate suggestions on proposed legislation?

Dr. CRONIN. I am not in that position in the Agency to answer, Mr. Chairman.

Mr. BUSBEY. You do not need to answer this if you do not wish, but what is the use of sending you a bill for comment if suggestions are not made with respect to amendments which will improve the legislation?

Let me ask you another question instead. Do you not think that this law could be amended so that it would be improved in the direction of affording greater protection to the taxpayers? Surely you have seen Federal money go into projects which you would not have approved if you had had the final determination?

Dr. CRONIN. Mr. Chairman, I would like to make one comment there. I would hate to think that we had a program where I had the final say on these projects because I think that I do not know enough about the needs of projects and local areas to be in that position. I think undoubtedly the Hill-Burton Act or any other act passed by Congress in years past may be improved upon in some instances. I think, however, before I would be willing to commit myself on whether the Hill-Burton Act could be improved upon I would want to have a whole lot more study given to the particular item that I would present for improvement than I currently know about.

I also feel that we would all probably be better off if the program were extended and the refinements made of it at a subsequent time rather than trying to amend the act and extend it all at the same time, because I feel that that might lead to definite misunderstandings or lack of understanding about the program, which might result in confusion and nonextension, which I think is important in this program.

Mr. BUSBEY. Why would it lead to confusion anymore at that time than at the time the legislation was first considered, when the law was first being written?

Of course, so far as the amendments are concerned, everybody knows that no legislation which Congress passes is perfect. Legislation in the final analysis is what? It is a compromise, a meeting of the minds. If we did not compromise we would never have any legislation.

I would have to take issue with you on the opinion that when a law is being extended, amendments ought not be considered. I think that that is the most appropriate time to consider amendments, because, if you do not, you can rest assured that no amendments will be made later. This law, for example, has stood on the books all these years without any amendment.

Dr. DEARING. May I add a point in regard to what I understand is the position of the Federal Security Administrator at the moment? On an invitation of the House Interstate and Foreign Commerce

Committee, which handles the basic legislation, sometime about a month ago the Federal Security Administrator did appear to tell about the program and plans as she could forecast them. She stated at that time she was not prepared to make a recommendation on legislation, and that consideration in connection with the Harris bill has been, so far, in line with general executive department policy, to recommend the extension, and that, I believe, has not yet been decided upon. They have not gotten to the question yet of what amendments to propose, or whether to propose any. It is in that stage now. Perhaps Mr. Stephens would care to add a word on that. That is my understanding of where the Federal Security Agency is at the present moment.

Mr. STEPHENS. That is the way I understand it. The new Administrator was not sufficiently familiar with the operations under the old law, and was only faced with a bill adding 5 years to its life, and obviously she was not so naive as to say, "I want to do it this way or that way." I do not believe she knew the administration policy with reference to it. After the report is prepared for the committee, the written report, it will go to the Bureau of the Budget, where ostensibly the Director and the President will discuss its connection with the overall administrative policy and then will say, it is okay to send this report, or do not send it. If you do send it, and our report is negative, tell the Congress what we said about it.

Mr. BUSBEY. Were letters sent from both committees, the Senate and the House?

Mr. STEPHENS. I believe so; yes.

Mr. BUSBEY. The response has not come back to the Congress yet?

Mr. STEPHENS. No, sir.

SOURCES OF NURSING STAFF

Mr. BUSBEY. Dr. Cronin, do you know of a report that appeared in the American Hospital Association journal of April 1952, regarding the taking of nurses from existing hospitals?

Dr. CRONIN. No, sir.

Mr. BUSBEY. I have a notation in my notes that 62 percent of the nurses for new hospitals were taken from existing hospitals. Could that apply to hospitals built under the Hill-Burton Act?

Dr. CRONIN. I could not venture a guess on that, I have never made a study about where these nurses basically came from. We have not had the facilities or the personnel to do so. I could not answer your question.

POSSIBILITY OF CANCELING CURRENT OBLIGATIONS

Mr. BUSBEY. How much have you obligated on this construction program that could be canceled?

Dr. CRONIN. I do not quite understand your question.

Mr. BUSBEY. For instance, there are certain obligations you have assumed with respect to hospitals which have not yet been started. Is there any ironclad rule of law that prohibits cancellation of such obligations?

Dr. CRONIN. Mr. Chairman, all part IV's which are contract documents in this program, represent projects which, within a 2-week

period, the construction will start on. In other words, the bids are in, the contracts are in, and they are ready to be let within 2 weeks.

Mr. BUSBEY. Then your opinion is there are no obligations that could be canceled?

Dr. CRONIN. I think that is correct. There may be some small moneys, minute portions, that could be dropped out, but I do not think that otherwise it would hold true.

AUDITING OF COMPLETED PROJECTS

Mr. BUSBEY. How many projects were not audited within 6 months after they were completed?

Dr. CRONIN. Mr. Chairman, you could help me and advise me by telling me what you mean by "completion."

Mr. BUSBEY. When a hospital is completed and ready to open and to take patients, I would say it is completed. How many projects were not audited within 6 months of the completion of construction. Naturally, that includes equipping.

Dr. CRONIN. Mr. Chairman, by completion, I would like to point that many projects are occupied and patients admitted before that project is formally completed. The need for beds in the area is frequently such that the patients occupy the beds, the hospital gets under way, but there are still items of construction that have not yet been finished up, and because of their location within the project site, do not interfere with patient care.

Now, we have an analysis of eight States that we can give you with reference to the time that those projects were audited. We have that material on eight States which we were requested to get up. That refers to the day opened rather than the date of project completion, because we have hospitals opened, but the project may be several months before it is formally completed.

Mr. BUSBEY. Have there not been instances where there has been a great deal of delay between the time the project opened and an audit of the project was made?

Dr. CRONIN. I would say "No." Running down this list we have a project that was opened in May of 1951 and the audit was done in October. Here is a project that was opened in April of 1950, and the audit was started in June of 1950. Here is one that opened on July 1951 and the project was started to be audited in September of 1951.

Mr. BUSBEY. Why are these audits not started sooner?

Dr. CRONIN. I would like to point out in that instance the audits on these projects are not controlled by the Public Health Service. The audit on these projects is not done by the Public Health Service in the first instance, they are done by the Federal Security Agency auditors, and in the second instance, the Federal Security Agency auditors start the audit when the State advises the Federal Government that the project is ready for audit.

Mr. BUSBEY. In other words, a hospital project could be completed, opened let us say, on January 1 of 1951, and the State, if it wanted to do so, could wait a period of 2 years before it would advise that it was ready for an audit?

Dr. CRONIN. I think that would be a very unusual situation.

Mr. BUSBEY. Even so, is there anything that would prevent a State from doing that?

Dr. CRONIN. From a practical point of view, the money would be needed by the sponsors to pay the contractors, and I am sure that they would not let the State wait that long. The project is eligible for Federal audit when it is 95 percent complete.

Mr. BUSBEY. That is right.

Dr. CRONIN. And when a project reaches 95 percent completion, our experience is that the sponsors want that audit as soon as they can get it so that they can get the money.

Mr. BUSBEY. They have already received 95 percent.

Dr. CRONIN. But to some of these communities that other 5 percent is pretty important.

Mr. STEPHENS. May I contribute this from my knowledge of the auditors? They have all the grant-in-aid programs, but I know that there are standing instructions to all the field auditors in the audit division that there are two kinds of audits that must be done promptly on call. One is this hospital construction, because the contractors are waiting for the final payment. The other is the school construction program where the last 10 percent is withheld until the final audit. The standing instructions to all the auditors are to forego public assistance, vocational rehabilitation, and so forth, in order to complete these two types of audits.

Mr. BUSBEY. But the auditors from the Federal Security Agency cannot make an audit until they get notice from the State agency that it is ready for the audit.

Mr. STEPHENS. That is right, sir.

Mr. BUSBEY. It seems ridiculous to me that a State should be able to wait a year and a half from the time a hospital is opened before it signifies that it is ready for an audit. It also seems to me that the delay in these audits would tempt some of the project sponsors to install additional equipment and other items in the hospital after it has opened in order to include them in the audit. An immediate audit would preclude the inclusion of such items in the project.

Mr. STEPHENS. The audits are against the contract, not something that might be added after the contract. They would immediately take an exception to that. If a school or a hospital had a contract that would call for certain items of construction in building and equipment, invoices would have to be in, and anything over and above the inclusion in the specifications, or the contract, would be excepted immediately by the auditors. They would not approve an item of that nature.

Mr. BUSBEY. So you do not think there is any opportunity for them to include any articles that were not in the original specifications?

Mr. STEPHENS. I do not believe so. They might not be technically aware of a substitution, or a thing of that nature, but they audit against a written document with specifications as to what is included to be paid for with the total money.

Dr. CRONIN. And that includes the equipment, Mr. Chairman. As a rule, they do not wait long.

Mr. BUSBEY. Restating the question in a different way, Dr. Cronin, by delaying the audit, do or could the sponosrs get Federal funds that they otherwise would not get?

Dr. CRONIN. The answer is emphatically no.

UNLIQUIDATED OBLIGATIONS, 1948–53

Mr. BUSBEY. Did I ask for a table of the unliquidated obligations for each fiscal year from 1948 to date?

Dr. CRONIN. Not yet, sir.

Mr. BUSBEY. Will you supply such a table for the record?

Dr. CRONIN. We will.

(The table referred to is as follows:)

Unliquidated obligations by fiscal years

Fiscal year:	*Amount*	Fiscal year—Continued	*Amount*
1948	$1,050,968	1951	$25,579,686
1949	3,203,038	1952	46,637,034
1950	13,775,406	1953	25,411,729

FEDERAL CONTROL OF STATE PLANS AND PROJECTS

Mr. BUSBEY. You stated that you do not exercise any control over State plans with regard to selection of projects; is that right?

Dr. CRONIN. We have no control over the selection of communities on a specific basis, but under the provisions of the law, the selection of the communities is predicated upon the need for the hospitals in those areas as reflected in the State plans which we approve.

Mr. BUSBEY. Under the Public Service Act, section 262 (e), you are responsible for the general standards of construction and equipment of hospitals at different prices and at different types of location. When I say "you" I refer to the Surgeon General, technically.

Now, your agency has been at this work since the law was enacted in 1946; is that right?

Dr. CRONIN. That is correct, sir.

Mr. BUSBEY. Have you not been able in great degree to formulate your general standards for construction and equipment?

Dr. CRONIN. Mr. Chairman, we have in compliance with this section that you referred to of the act, promulgated the regulations which are, as regulations should be, in a state of flux, and are changed as new problems come up and solutions are arrived at. I might indicate to you that these regulations cannot be promulgated and put into effect until they have been approved by the Federal Hospital Council. The Surgeon General does not have the authority to promulgate regulations unless they are approved by the Federal Hospital Authority, and that is in the act.

SALARIES AND EXPENSES, HOSPITAL CONSTRUCTION SERVICES

WITNESSES

DR. JOHN W. CRONIN, CHIEF, DIVISION OF HOSPITAL FACILITIES
DR. JOAN McGIBONY, CHIEF, DIVISION OF HOSPITAL FACILITIES

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$1,230,115	$1,200,000	$1,200,000
Reimbursements from non-Federal sources	1,971		
Total available for obligation	1,232,086	1,200,000	1,200,000
Unobligated balance, estimated savings	−6,433		
Obligations incurred	1,225,653	1,200,000	1,200,000

NOTE.—Reimbursements from non-Federal sources above are from the proceeds of sale of personal property (40 U. S. C. 481 (c)).

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
1. Operations and technical services activities	$1,117,244	$1,090,440	$1,090,440
2. Administration	108,409	109,560	109,560
Obligations incurred	1,225,653	1,200,000	1,200,000

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Total number of permanent positions	185	185	185
Full-time equivalent of all other positions	1		
Average number of all employees	176	173	173
Average salaries and grades:			
General schedule grades:			
Average salary	$5,731	$5,849	$5,849
Average grade	GS–8.3	GS–8.4	GS–8.4
Crafts, protective, and custodial grades:			
Average salary	$2,712	$2,765	$2,765
Average grade	CPC–3.0	CPC–3.0	CPC–3.0
01 Personal services:			
Permanent positions	$1,069,850	$1,084,432	$1,084,432
Part-time and temporary positions	3,722		
Regular pay in excess of 52-week base	3,349	3,468	3,468
Total personal services	1,076,921	1,087,900	1,087,900
02 Travel	77,905	65,000	65,000
03 Transportation of things	10,110	3,500	3,500
04 Communication services	2,909	3,000	3,000
05 Rents and utility services	16		
06 Printing and reproduction	21,576	9,000	9,000
07 Other contractual services	13,071	11,700	11,700
08 Supplies and materials	10,776	10,000	10,000
09 Equipment	11,489	9,000	9,000
15 Taxes and assessments	880	900	900
Obligations incurred	1,225,653	1,200,000	1,200,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$158,636	$108,911	$128,911
Obligations incurred during the year	1,225,653	1,200,000	1,200,000
	1,384,289	1,308,911	1,328,911
Deduct:			
Reimbursable obligations	1,971		
Adjustment in obligations of prior years	48,525		
Unliquidated obligations, end of year	108,911	128,911	148,911
Total expenditures	1,224,882	1,180,000	1,180,000
Expenditures are distributed as follows:			
Out of current authorizations	1,120,192	1,072,000	1,112,000
Out of prior authorizations	104,690	108,000	68,000

GENERAL STATEMENT

Dr. CRONIN. This request for $1,200,000 is to continue the program in 1954 at the same level of appropriation as in fiscal year 1953. Periodic and longevity increases would be absorbed in 1954.

These funds are utilized to pay for a central office and field staffs who are, essentially, specialists in the programing, planning, design, construction, and equipment of hospitals, health centers, and related facilities. Orderly development of a hospital program is essential.

With continuance of the construction phase of the program, mandatory functions must be carried on, such as approval of annual State plan revisions, review and approval of construction plans, specifications, contract documents, surveillance of bid and award procedures, project inspections, and approvals of requests for Federal payment. A minimum amount of resource and guide material development is essential to insure the continuance of a quality program in tune with rapidly changing concepts of medical and hospital care.

In my opinion the salaries and expenses appropriation for this program are now at the minimum level necessary to carry out mandatory functions and furnish some fundamental leadership and guidance to the States. Minimum standards and established procedures must be adhered to by the States and project sponsors. Any reduction below the amount currently available to administer our activities would imperil the safeguards which the Public Health Service is required to exercise in protecting the Government's investment in these projects and insure compliance with the basic provisions of the law.

Mr. BUSBEY. In your organizational chart I notice that you have 23 positions in your Technical Services Branch, and it looks as though all but six of those positions are grade 12 and above. Why is it necessary to have such a large Technical Services Branch? What do these people do?

TECHNICAL SERVICES BRANCH, DIVISION OF HOSPITAL FACILITIES

Dr. CRONIN. Those 23 positions are those positions occupied by a group of highly trained technical people, and by that I refer to such men as have competence in the area of hospital architecture, electrical engineering specialist, hospital architects in the area of mental hospital architecture, tubercular hospital architecture, chronic disease hospital architecture, and so forth. These people are of high caliber because of their educational and experience background. In my opinion, we are lucky to have people of that character and competence in grade 12, and it is a marvel to me that they stay with us at that figure.

Mr. BUSBEY. I do not doubt that at all. The only thing I am attempting to ascertain is what their duties and responsibilities are. Do they work here in Washington, or in the field?

Dr. CRONIN. Those 23 people, Mr. Chairman, although based here in Washington, work both in Washington and in the field. For example, I have one electrical engineer on this whole program to cover all the research work, the administrative work, and the field work necessary and the electrical engineering for the whole country. When I think that we have a program that now encompasses 2,000 projects, every one of which has electrical features, and that one electrical engineer is servicing that whole area, it is remarkable.

The same thing can be said of the structural engineer.

Mr. BUSBEY. I do not see how he can do all that and do a good job.

Dr. CRONIN. All that you can do in our role is consultation, guidance on principles.

Mr. BUSBEY. Do they have any control, through delegated authority, over State plans and projects?

Dr. CRONIN. They have no authority whatsoever. Their work is entirely on the basis of educational activities, but they can carry on at the request of the State agencies, and at the request of my regional construction engineer and architect when he has a problem.

I would like to cite an instance: There has been a considerable problem in the area of operating room floors being nonconductive of electrical potentials. Our electrical engineer, Mr. Griffin, has been working with the Bureau of Standards, and is one of the group that devised the placing of carbon black into the terrazzo floors to make them nonconductive so we can in some small way make our contribution to offset operating room explosions. We have other men on our staff who are recognized, and who have received national awards for such services.

HEADQUARTERS AND FIELD ORGANIZATIONAL UNITS

Mr. BUSBEY. How many different branches do you have in the headquarters and in the field?

Dr. CRONIN. In headquarters we have the Office of the Chief, which is my office, and is an administrative operation. We have the Technical Services Branch, which we have just discussed. We have an Evaluation and Reports Branch, which is our statistical section. We have a Program Operations Branch and the Equipment Branch.

Under the program also is the professioanl services group, which is located in the Division of Hospital and Medical Resources.

In the field we have 10 regional offices of the Federal Security Agency, but only 9 of those are we staffing with hospital facilities, Hill-Burton people. In those areas where we have people there is one program director who is a physician trained in the field of public health and hospital administration, and with a working knowledge of hospital construction and community planning, and so forth; one hospital program representative who is a person trained in medical economic social aspect of planning and helping communities, and so on; one hospital architect; one hospital construction engineer; and one hospital mechanical engineer.

I would like to point out that in regard to the mechanical engineer, because of the shortage of money, we do not have 9, we have only 6 at the present time, and some of those men are covering such large areas as the Kansas City region and Dallas region together, which encompasses all the State between the Mississippi River and the Rocky Mountains, running north and south.

Mr. BUSBEY. Dr. Cronin, would you prepare a table for the record at this point showing the number of positions in these different branches, and showing at the bottom the total number of positions.

Dr. CRONIN. Yes.

Mr. BUSBEY. It would be helpful if you made a notation of the number of positions that are grade 9 and above.

(The information requested is as follows:)

Table of positions by branch under appropriation "Salaries and expenses, hospital construction services"

DIVISION OF HOSPITAL FACILITIES—DEPARTMENTAL

Office of the Chief:	
Chief of Division, director grade	1
Assistant Chief of Division, senior grade	1
Executive assistant, GS–13	1
Clerical assistants, GS–4 to GS–6	3
Messengers, CPC–3	2
Total, Office of the Chief	8
Technical Services Branch:	
Chief, director grade	1
Assistant Chief, GS–14	1
Chief, architect, GS–13	1
Hospital architect, GS–13	1
Hospital architects, GS–12 (building type specialists)	7
Hospital construction engineer, GS–13	1
Architectural engineer, GS–13	1
Structural engineer, GS–13	1
Mechanical engineer, GS–13	1
Electrical engineer, GS–13	1
Cost engineer, GS–12	1
Architectural exhibit designer, GS–9	1
Clerical assistants, GS–3 to GS–5	5
Total, Technical Services Branch	23
Program Operations Branch:	
Chief, GS–14	1
Chief, Field Liaison Section, GS–13	1
Chief, Program Analysis Section, GS–13	1
Hospital program analyst, GS–12	2
Hospital program analyst, senior assistant grade	1
Clerical assistants, GS–4 and GS–5	4
Total, Program Operations Branch	10
Evaluation and Reports Branch:	
Chief, senior grade	1
Assistant Chief, GS–13	1
Clerical assistants, GS–3 to GS–8	7
Total, Evaluation and Reports Branch	9
Hospital Equipment Branch:	
Chief, senior grade	1
Hospital consultant, senior grade	1
Hospital equipment specialist, GS–12	1
Hospital equipment specialist, senior assistant grade	1
Clerical assistant, GS–5	1
Total, Hospital Equipment Branch	5
Total, departmental, Division of Hospital Facilities	55

Table of positions by branch under appropriation "Salaries and expenses, hospital construction services"—Continued

FIELD

Hospital program directors, 4 director grades, 5 senior grades, 1 GS–14	10
Hospital architects, 9 GS–13 and 3 GS–12	12
Hospital construction engineers, 8 GS–13 and 1 GS–12	9
Hospital mechanical engineers, 4 GS–13 and 4 GS–12	8
Hospital program representatives, 1 GS–13 and 9 GS–12	10
Clerical assistants, GS–3 to GS–7	31
Total, field, Division of Hospital Facilities	80
Total, departmental and field, Division of Hospital Facilities	135

DIVISION OF MEDICAL AND HOSPITAL RESOURCES—DEPARTMENTAL

Office of the Chief:	
Chief, director grade	1
Program coordinator, senior grade	1
Clerical assistants, GS–5 and GS–6	2
Total, Office of the Chief	4
Clinical Services Branch:	
Chief, senior grade	1
Nurse consultant, senior grade	1
Nurse consultant, full grade	1
Laboratory consultant, senior grade	1
Public health research analyst, GS–9	1
Clerical assistants, GS–3 and GS–5	2
Total, Clinical Services Branch	7
Medical, Hospital Administration Branch:	
Chief, senior grade	1
Hospital administrative consultant, full grade	1
Hospital administrative consultant, senior assistant grade	1
Hospital accounting consultant, GS–11	1
Clerical assistant, GS–4	1
Total, Medical, Hospital Administration Branch	5
Medical, Economics Branch:	
Chief, GS–13	1
Health economist, GS–12	1
Health economist, GS–11	1
Health economist, GS–9	1
Clerical assistant, GS–4	1
Total, Medical Economics Branch	5
Professional Reference Section:	
Public health program specialist, GS–12	1
Clerical assistants, GS–2 to GS–7	4
Total, Professional Reference Section	5
Program Operations Branch:	
Chief, senior grade	1
Clerical assistant, GS–4	1
Total, Program Operations Branch	2
Total, Medical and Hospital Resources	28

Table of positions by branch under appropriation "Salaries and expenses, hospital construction services"—Continued

ADMINISTRATIVE ACTIVITIES—DIVISION OF HOSPITAL FACILITIES AND DIVISION OF MEDICAL AND HOSPITAL RESOURCES

Administrative officer, GS–11	1
Clerical assistants, GS–2 to GS–7	5
Total, administrative activities	6
Bureau of Medical Services:	
Associate Bureau Chief, Assistant Surgeon General	1
Bureau information officer, GS–13	1
Artist-illustrator, GS–11	1
Financial operations officer, GS–11	1
Financial operations officer, GS–9	2
Clerical assistants, GS–4 to GS–7	5
Messenger, CPC–3	1
Total, Bureau of Medical Services	12
Bureau of State Services:	
Statistician, GS–9	1
Clerical assistants, GS–3 and GS–4	3
Total, Bureau of State Services	4
Grand total, number of positions	185

Dr. CRONIN. I think that you will find that we have a considerable number of grade 9 and above because our staff is a professional staff requiring engineers, or degrees in medicine or architecture, and so forth.

Mr. BUSBEY. I am trying to understand why it is necessary to have so many positions, when under the law you are charged only with developing general standards. Inasmuch as you do not have any control over the State agencies, it seems to me that you have a great number of personnel for that function.

Dr. CRONIN. Mr. Chairman, I would like to comment on that. We have approximately half of our staff in headquarters and half in the field. I would like to point out it is a definite responsibility of the staff in the field to review each project application after it has passed through the State level to ascertain whether or not that project is designed architecturally sound and conforms to the minimum standards set forth by the law and regulations promulgated pertaining to that law. The authority of the technical people in the regional offices is very definitely one of major concern for the simple reason if those people do not think that these projects are architecturally sound, or conform to the minimum standrads set forth in the law, we have the right to disapprove the project and that requires, Mr. Chairman competent engineers and architects to review those projects in the field.

Mr. BUSBEY. You are asking for $1,200,000 for salaries and expenses for the hospital construction services.

Dr. CRONIN. That is correct. That is exactly the same as we had this year.

FUNDS REQUESTED OF BUDGET BUREAU

Mr. BUSBEY. And what did you ask the Bureau of the Budget for?

Dr. CRONIN. $1,250,000.

FIELD STAFF OF DIVISION OF HOSPITAL FACILITIES

Mr. BUSBEY. In addition to your Technical Services Branch, I notice you have 80 positions in the regional staff.

Dr. CRONIN. We have 80 positions in the field, and the Technical Services Branch is one of the 4 branches at the headquarters level. In the Technical Services Branch there are only 23 positions at headquarters. The other branches have other people.

Mr. BUSBEY. That is what I say, in the regional staffs you have 80 positions listed.

Dr. CRONIN. That is correct.

Mr. BUSBEY. Do they do some of the same work that the people in the Technical Services Branch do, or just what is their function?

Dr. CRONIN. The field people, Mr. Chairman, are the people who have to review each one of the projects in this program. They are located in nine regional offices, and are the people that have competence in the field of architectural engineering, construction engineering, mechanical engineering, and the program director is trained in the field of hospital administration and public health and construction activities in general. These people are charged with the responsibility, because under this program we have delegated to our field operations the responsibility for approving the projects after they have been checked by the State agencies.

DIVISION OF HOSPITAL AND MEDICAL RESOURCES

Mr. BUSBEY. You mentioned something about the Division of Hospital and Medical Resources. What does that Division do?

Dr. CRONIN. That Division is a twin division, or sister division of the Division of Hospital Facilities and has in it the professionally competent people in the area of medicine, nursing, and pharmacy, and the professional aspects of a hospital as distinguished from the technical aspects of a hospital needed for construction.

Those individuals in that Division assist our architects and engineers in developing guidelines and the prototype plans which have been developed under this program that the architects of the country have followed very closely and are begging for in the whole field of hospital architecture.

We feel in the planning of a hospital the first thing that is necessary, of course, is a written plan of the program, what that hospital will do; secondly, that in that planning you cannot design a hospital adequately unless you have advice and consultation from the people who are going to use that hospital. Those people include the surgeon who will operate in the operating room, the nurses who will assist at the operation, the nurse who will give bedside nursing care, the dietitian who will serve the meals, the stationary engineer who will fire the boilers and keep the plant going.

That type of competence is necessary for architects to be able to design a hospital, and those kinds of persons and their competency are located in the Division of Hospital and Medical Resources to give aid and assistance to the architectural staff that I have in the design of prototype plans such as this book that I have in my hand, the Elements of General Hospitals. I would like to read a minute, if you will permit me, from the introduction of these elements. This

statement is written by Mr. George Bugbee, who is the executive director of the American Hospital Association:

> The elements of the general hospital that appear in these pages represent the last work in this pooling of ideas and experience. They have been brought completely up to date and include all additions and revisions that have been made since they first appeared in 1946.
>
> These elements represent the work of many organizations and individuals. But in the final analysis the credit goes, without question, to the Public Health Service of the Federal Security Agency. The Public Health Service, through the Division of Hospital Facilities, has contributed immeasurably to the improvement of hospital design in the United States and indirectly throughout the world. The Public Health Service, the Surgeons General who have supported this work, and the skilled individuals who thought out and worked out the complex details deserve much credit for the improvements in hospital design which they have made.
>
> Certainly the Elements of General Hospitals are an excellent example of cooperative activity between the Public Health Service and the hospital field. They have made and will continue to make a significant contribution to the improvement of hospital design and, through better planning, to the improvement of patient care in this country and throughout the world.

The only thing, Mr. Chairman, I think that could have been added to that statement was the approval perhaps of the Congress, which had made the money available for this purpose.

Mr. BUSBEY. How much of the $1,200,000 is allotted to this Division?

Dr. CRONIN. $160,800.

COOPERATION WITH DIVISION OF HOSPITAL FACILITIES

Mr. BUSBEY. Do the people in this Division cooperate with the other division in looking over hospital plans, and do they take into consideration the problems of maintenance of a hospital after it is built?

Dr. CRONIN. Dr. John McGibony, who is the Chief of that Division, is here, and I think that that question should be directed to him. I am not refusing to answer that question but I think he, as Chief of that Division, can be more informative than I can.

Mr. BUSBEY. The policy in the committee is to let anyone answer who has the information.

Dr. CRONIN. I think it is important that he answer, for this reason, because he is in direct charge of that Division, and they do cooperate with my Division and do assist my people. But I think he, because he is closer to that operation than I, is in a better position to tell you and answer your question about their activities.

Dr. MCGIBONY. The responsibility that the Public Health Service has under the Hill-Burton program includes providing assistance to the States and communities, and seeing that they get their dollar's worth in the facilities that are planned and built. Our job primarily is to work very closely with Dr. Cronin's technical group, keeping in mind at all times the patient and the care that he gets in the facility; to see to it that the facility is so planned that it will be efficiently and economically operated and can be so maintained. That approach is purely through the development of guide materials.

As an example, we have one person who spends a great deal of time, or has in the past months, in developing guide material on blood banks, which is in a rapidly increasing status in hospitals. An architect, in order to design a proper blood bank, has to know what goes in there,

what equipment is required, what demands are made on it, what the staffing and equipment layout is, in order for the hospital to operate efficiently and render adequate standard of care to the patient. That is an example of the type of activity that we carry on.

ADVICE CONCERNING HOSPITAL MAINTENANCE PROBLEMS

Mr. BUSBEY. Does your Division admonish the promoters of these hospital projects as to what their problems will be in maintaining the hospital after it is completed?

Dr. MCGIBONY. Only through the development of guide material. As an example, we have Elements of Hospital Operations, which was developed after much study with individual hospitals already in existence and with various specialists in the field, in which we attempt, for guide purposes, to set down for new hospitals the 3,000 things that one must think about before a patient is taken into a completed building.

Mr. BUSBEY. I was wondering how many of these communities start a hospital project without giving thought to how they are going to maintain the hospital after it is completed. I do not know of any particular instance, but I am under the impression that some of the communities find that maintenance and operating costs are much greater than they had anticipated. Does your Division give them counsel on the operations end of the project?

Dr. MCGIBONY. We do. We have a person who spends most of his time following the trends in hospital operating costs so that we can pass along, as information to a community, that if they plan a hospital or open a hospital, what the expected costs will be. Guide material along that line is made available for their use.

Mr. BUSBEY. What is your relationship to hospitals after they are opened?

Dr. MCGIBONY. We have no direct relationship. All of our activities are purely in an advisory capacity with Dr. Cronin's group through the State agencies. We get a great deal of material returned to us from the operating hospitals, purely voluntarily on their part, so we can pass it on to other new hospitals to help solve their problems.

Mr. BUSBEY. Do you administer any program for the training of hospital personnel in the techniques of operating a hospital?

Dr. MCGIBONY. We do not have in our Division a staff to do that type of thing. That is accomplished largely through what we hope is a stimulus to the State agencies, the State hospital associations, working in cooperation with the American Hospital Association, and having them put on institutes or conferences on various subjects.

PROVISIONS OF HILL-BURTON ACT

Mr. BUSBEY. I was just wondering if the functions that are being carried out by the Division of Hospital and Medical Resources were contemplated in the original Hill-Burton Act.

Dr. MCGIBONY. Yes. This activity was started when the original staffing pattern was set up, and people now with the staff have been with the program since the initial act was passed. We anticipated, from the number of requests that came in from the States and communities for assistance, that there would be an enlargement of the

activity, and the Congress authorized such an activity in the amendment to the act at the time that it was increased to $150,000,000. This set forth a specific study and demonstration program to which Dr. Cronin referred this morning; but, since additional funds were not made available for this new activity, we have continued to operate on exactly the same basis as the original act authorized.

ADMINISTRATIVE SERVICES

Mr. BUSBEY. Are the administrative costs taken care of by this $160,800 you referred to for this Division, or are they taken care of by the Administrator's Office?

Dr. MCGIBONY. All the administrative activities for both Divisions are handled by the one staff. There is no duplication of activities in that area.

Mr. BUSBEY. Dr. Cronin, does your Division come under the same obligation that the other Division comes under in having to contribute a part of its appropriation for general administrative services?

Dr. CRONIN. We do give part of the appropriation for administrative services at the administrative level above us, in return for which they give us services in the area of personnel and recruiting and general administrative services incidental to the total activities of the program, such as budget work, and so on.

Mr. BUSBEY. What does that amount to per year, approximately?

Dr. CRONIN. Approximately $53,000.

Mr. BUSBEY. Mr. Stephens, one of the many rumors that has come to me is to the effect that the appropriation request for the Administrator's Office is going to be increased. Assuming that to be the fact, will it be necessary to continue this $53,000 appropriation for central administrative services, or does that appropriation have anything to do with the Administrator's Office at all?

Dr. CRONIN. No, sir; that is a service that we receive from the Bureau of Medical Services itself. In the organizational setup of the Public Health Service, we the Division of Hospital Facilities and the Division of Hospital and Medical Resources, are organizationally placed under the Bureau of Medical Services, and in the Bureau of Medical Services there is a Division of Administrative Management, and it is into that Division of Administrative Management that part of this $53,000 goes. The other part of it goes to the Office of the Chief of the Bureau of Medical Services to support his assistants or associate chief, and their secretaries, and those positions are all necessary in the overall administration of the Bureau activities, and we pay our share of that overall supervision and administration.

BUDGET ESTIMATE RELATED TO GRANT APPROPRIATION

Mr. BUSBEY. About how much of this request of $1,200,000 for salaries and expenses is for work that will be done in connection with the additional $75 million in grant money you have requested for 1954, and how much is for work in connection with grant funds already appropriated?

Dr. CRONIN. I really do not understand how that can be separated. The $1,200,000 we receive for the conduct of the Hill-Burton program is entirely spent in the operation of the conduct of the Hill-Burton

program, and we are required to come before the Congress and the Budget Bureau, and so forth, in support of whatever amount the President includes in his appropriation budget, and that is a part of our routine activity, regardless of whether it is $75 million or what it may be in any one year. That is part of the operational activity of any division or any program in the United States Government.

Mr. BUSBEY. Surely if none of the $75 million were appropriated by the Congress, you would not need as much staff to handle this work, would you?

Dr. CRONIN. I think, Mr. Chairman, we would need exactly the staff we have and more, if we could get them, for the very simple reason I do not think we will ever be able to do the job that should be done in regard to Hill-Burton hospital construction in this country. I think it is only right to point out that there are 750 projects under construction at this time, and these 750 projects require such activities out of the Federal Government as review of the projects in the beginning, assistance to the States whenever the change orders occur on the project, and to the local sponsoring groups technical help when they get into trouble, for instance, the electrical field, and in the general support of these projects I do not see how it can be done with much less staff than we have.

Mr. FERNANDEZ. I know better than to try to predict what the committee will do, but I will predict that Congress will not cut out the $75 million for hospital construction. It just cannot afford to do that. So I think that we need not worry about how much we can cut the administrative expenses if the other amount is eliminated.

Mr. STEPHENS. I might add this to what Dr. Cronin said about needing all his staff. I can conceive if you do not appropriate a nickel he would need all of his staff for at least another year. Of course, eventually they would all disappear.

Mr. FERNANDEZ. I think that is wholly academic. We cannot afford to do otherwise than appropriate funds for construction.

Dr. CRONIN. If there were a reduction in our staff to administer this program, we would be faced with a very real problem in the total economics, and that problem is the remaining staff. If it were reduced much below what it is now, they would not stay with us for the simple reason that these people—and I would like to give credit to them—are highly trained professional personnel that I can assure you are not wanting for jobs. With industry in the country the way it is there is not one on my staff who could not go out today and get a much better paying job than he now has. When I think that we have electrical engineers, architectural engineers, and construction engineers on the staff at grade 12 and 13 levels, as I said before, in my opinion there is only one thing that holds them there, and that is service to their country and the fact that they know they are working on a program which is accepted and is good and worthwhile, and to them I would like to give the credit for the operation of this program.

Mr. BUSBEY. I do not think that you can confine that remark necessarily just to your own agency. I think that is true to a great extent throughout government.

Dr. CRONIN. I think you are right, Mr. Chairman, but it is my responsibility to administer this particular program with the people that I have, and I have a great deal of respect for them, and their position, and what they are doing, because I, myself, am in the same boat, and I know how I feel about it.

RATE OF PERSONNEL TURNOVER

Mr. BUSBEY. I take it that most of these positions have been filled by the same people for some years. You do not have a large turnover, do you?

Dr. CRONIN. We have practically no turnover, and I think it is regrettable that in the last 3 years we have had to reduce our staff because of shortages in appropriations, and if we reduce our staff it is not good moralewise because the men feel—what is coming next and what is going to happen—and we have hired no new people at all in this program for over 2 years. We have lost a number of people to the Army and the Navy who are off on military furloughs. We hope that those people can come back. If this appropriation is reduced emphasis on the program will have to be changed, and I think we would be in a deplorable situation.

PROJECT PRIORITIES

Mr. FERNANDEZ. I think that you have covered the field very well and thoroughly, Mr. Chairman.

You were speaking about priorities this morning, and it was stated that the fact that priority A areas may be shown in a State as receiving less money than priority B, C, or D, does not necessarily reflect that the need for priority A had not been taken care of. Did I understand that to be the case?

Dr. CRONIN. Mr. Fernandez, the implication of that is that in some areas, A priority, they are unable to be taken care of because they, themselves, cannot come up with the money due to their economic status.

Mr. FERNANDEZ. What I had in mind, though, is priority A areas may have less money, yet the fact may very well be that their needs, so far as funds are concerned, are not as great as the needs of priority B or C.

Dr. CRONIN. That could happen.

Mr. FERNANDEZ. And, also, the State in this program has a very great responsibility, which I think the States have been carrying out very well, with respect to determining just where those hospitals shall be built, and it may occur on occasions that priority B may be taken care of by hospitals built in priority C after the State has made its survey and has decided that that is the best place to build the hospital.

Dr. CRONIN. That is a possibility but by and large the State surveys indicate the areas of higher priority and the construction schedules to a great extent follow those priority areas provided, of course, the communities have money to come up with it.

Mr. FERNANDEZ. But it may turn out on many occasions that they do not have the money. By perhaps giving a little more to priority C it will be possible to take care of some of the problems in priority A areas.

Dr. CRONIN. That happens, sometimes.

FUNCTION OF AUDITS

Mr. FERNANDEZ. The same thing is true with respect to audits. I believe the chairman will be very well pleased with this program, or should be, because here the State has not only a very large responsibility in footing two-thirds of the bill but also in running all of the business with the least interference on the part of the Federal Government. Since they are running their own business and footing two-thirds of the bill, the States are very careful about the funds expended in the construction of these buildings. So the audit is not quite as important, is it, except to see that it does comply with the Federal program?

Dr. CRONIN. That is correct. The auditor, Mr. Fernandez, audits against what was approved, and does not audit against philosophy or principle or anything else. They have to audit against what that community, its State, and the Federal Government signed their names to as the project.

DEGREE OF FEDERAL CONTROL

Mr. FERNANDEZ. Dr. Cronin, this morning in answer to a question from the chairman I understood you to say that the Hill-Burton program is one of the best safeguards against socialization of medical service. Did I understand you correctly?

Dr. CRONIN. That is how I feel; yes, sir.

Mr. FERNANDEZ. And you pointed to the fact that the medical association and the medical world feel the same way about it—with which the chairman agreed, I thought—and that the lay leaders in both parties also feel the same way about it. Proof of that is, is it not, that the bill was passed with the cooperation of such men as Senator Taft and Senator Hill on both sides of the aisle, and has been in successful operation for all these years.

Dr. CRONIN. I think that is correct, Mr. Fernandez. In addition to that, from my reading of the newspapers, this program was mentioned by both political candidates for the Presidency in their campaign speeches and is also a part of the American Medical Association's 10-point platform for their stand.

Mr. FERNANDEZ. I have a clipping here of an editorial which, in the light of that question, I think ought to be made a part of the record, Mr. Chairman.

Mr. BUSBEY. Without objection, we will include it in the record at this point.

Mr. FERNANDEZ. It is an editorial from the March 1953 Journal of the American Hospital Association.

Thank you, Mr. Chairman.

(The information is as follows:)

HILL-BURTON AND THE FUTURE

What future course should the Hill-Burton hospital survey and construction program take following the expiration of the act in 1955? This question is of paramount importance to the hospital and health field. Should it be continued much as it is in its present form? Should it have added Federal financial support? Should the association continue to support this program? Has the program served its purpose, thus eliminating the need for any further Federal action after 1955?

Should an entirely new type of program replace the present Hill-Burton program?

Before any definite decision can be reached, much detailed and exhaustive study of the present Hill-Burton program is necessary. Some surveys and evaluations of the program are already being made by the Public Health Service and State agencies as well as by the association.

To help analyze and evaluate the program a series of four conferences are scheduled for this spring. These conferences, being conducted under the auspices of the association, will bring together State hospital association officers, State planning agencies, representatives of the Public Health Service, and other groups and organizations intimately concerned with the distribution of hospital facilities.

As an aid to bringing before the field factual information about the Hill-Burton program as it has operated since its inception in 1946, the association has been conducting surveys and evaluations in some of the States. Details of these are featured in the article, Hill-Burton—Promising Answer to the Nation's Needs on page 49 of this issue of the journal.

On every count, the Hill-Burton program, from these surveys, and from other reports and evaluations conducted by other groups or organizations, appear to be meeting a real need in an effective manner. On a statewide planning basis, much has been accomplished for the good as a result of Hill-Burton. There is now far greater awareness of the desirability of community, State, and regional planning for hospital construction.

Hill-Burton hospitals visited report that they are not hampered by a lack of medical staff members. In some instances, these hospitals report that additional physicians have come into the community as a result of having modern hospital facilities available to them.

In regard to professional nurses and technicians, Hill-Burton hospitals do not seem to have any more severe problems than confront other hospitals. Some of the new hospitals reported that they have been able to attract local residents who had retired from the nursing profession to become active on the nursing staff of their new hospital.

The reports reveal that these hospitals are making extensive use of practical nurses, with a number of hospitals establishing programs for training practical nurses and others cooperating with local high schools and colleges in training activities.

Financially, most of the Hill-Burton hospitals, are not in serious difficulty. Rural areas where there had been no facilities prior to Hill-Burton find that acceptance of the hospital requires time.

The almost 100,000 beds constructed under Hill-Burton have increased the nation's acceptable beds to 54 percent of the estimated total need. Much is yet to be accomplished. How this is to be done requires the best thinking and leadership of the hospital field and of all other organizations concerned with high standards of hospital care.

One vitally important aspect of the Hill-Burton program, which is an outstanding example of government supplementing voluntary effort, is the fact that millions more of our citizens have hospital facilities accessible to them where previously, there were none or those that existed were inadequate or obsolete.

Accent On Practical Planning

Problem-Solving Designs, the journal's special construction section for 1953, represents a welcome change of pace. Until now construction issues have featured complete plans for each Hill-Burton hospital on display. This issue consists of plans for individual departments, which have solved or ameliorated some administrative problem.

These plans prove that the worth of any design depends on how pleasantly it can simplify human activity. Translated to administrator's terms this means more efficient service to the patient at a minimum cost for supplying it to him. The construction section, then, focuses on how many steps there are in a corridor, how central the nurses' station can be, how many patients can make use of laboratory services at the same time.

The wise administrator who, like the enterprising architect, plans constantly will find almost endless opportunity here. And if his studying results in one solution more feasible or an entirely new approach to a special problem, he will have accomplished exactly what the journal's contributing architects have hoped he would do.

Mr. FERNANDEZ. Now, what is socialization?

Dr. CRONIN. You want me to answer that?

Mr. FERNANDEZ. You said that you thought it was a safeguard against socialization of medical services. I just wondered what socialization is.

Dr. CRONIN. Well, I would like to say as I mentioned last year before this committee, that there are quite a few different definitions of socialization. The thing I think most people in this country fear is bureaucratic control at the Federal level to the extent that there would be interference between and intervention into the relationships of the physician and his patient. I think that is what perhaps most people would accept as socialization in the medical field.

Mr. FERNANDEZ. I think that this program was established and is being run with as little Federal interference as possible, and so I was wondering awhile ago when you were talking about extending the law whether or not it is quite wise to attempt to amend the law while extending it, because as I intimated awhile ago I feel so strongly that the Congress cannot do anything else but extend it. Advocates of a little more Federal control might want to put in amendments that we might not want. I think amendments should be considered on their own merits, when we do not have this pressure on us.

It reminds me of the Taft-Hartley Act, and the union men wanting us to repeal the Taft-Hartley Act and then start anew. That was because they were sure then they would not have that pressure and it would be much easier to put in their amendments and not have them vetoed, whereas if they put the amendments in along with the repeal of portions of the Taft-Hartley Act they would run up against the possibility of a veto.

That is a little philosophizing on my part, Mr. Chairman.

Mr. BUSBEY. It is your privilege.

FEDERAL RESPONSIBILITY IN HOSPITAL CONSTRUCTION FIELD

Mr. FERNANDEZ. Now, during the same period that we have expended about $500 million on this program we have also expended $200 million or $250 million, approximately, to stamp out the hoof-and-mouth disease in Mexico. We expended many millions of dollars in the same program for the States back in the 1920's. We have expended during these years millions of dollars for the eradication of hog cholera and other livestock and poultry diseases.

Separate and apart, Doctor, from the absolute necessity for aid in building these hospitals that the country needs, do you not think that the Federal Government has some responsibility in the matter of providing hospitals for the Nation as a whole?

Dr. CRONIN. I think the Hill-Burton program, Mr. Fernandez, is the answer to your question. I think that the Federal Government representing the will of the people has the responsibility of assisting the people to get adequate health care, of which hospitals are a part.

I also feel definitely that what method that takes is entirely up to the people of the country. I do not think I have the answer. I think my feelings on it would not be and should not be taken as the last word.

I do not personally feel, if you are asking me the direct question, that the Federal Government should operate all the hospitals in the

country at this time. I think that decision is something that would have to be approached after a great deal of study and something we do not know now the rights and wrongs to, at this time. We have seen some of these kinds of programs tried in some of the other countries in the world. Some of them have been a success and some of them have not been.

There is no other country that has an identical cultural pattern to what we have. I do not know of any program in any country today that is really offering us in this country any more than we now have, with our present cultural pattern. What the answer is I do not know.

Mr. BUSBEY. Will the gentleman from New Mexico permit me to make an observation at this point?

Mr. FERNANDEZ. Certainly.

Mr. BUSBEY. That, in my opinion, was not only a direct question, as Dr. Cronin referred to it, but in the language of the attorneys it was a leading question.

Mr. FERNANDEZ. Well, I thought I would save time by a few leading questions. I have a few more.

I would like to know whether in the opinion of the men who are charged with this program they consider it one of aid and charity to those poorer States like mine, which do not have facilities with which to build these large hospitals, or whether they feel that it is also based on a recognition of Federal responsibility. I think perhaps you have answered that question.

Dr. CRONIN. Well, since you have refined your question I will refine my answer a little bit. I think there is not any question but that the Hill-Burton Act is enabling communities that have not, to have. There is not any question in my mind that in the overall defense of our Nation against disease and to assist our Nation to combat the forces from without, that health is an essential and imperative thing. It is the basis of our economy. Anything we can do that does not go contrary to the basic will of the majority of the people—which, after all, is what controls in a democracy—is perfectly all right to do. I think there are responsibilities of those who have for those who have not.

I do not basically feel, however, that those who have not should be parasitical on those who have, and make no contribution. I would make no inference that anybody has done so. I think we all have a little bit of this boat to pull, and I think we are all trying to get each one in a position to pull this boat.

Mr. FERNANDEZ. Would you say, Doctor, that the Hill-Burton program is leading toward the operation of the hospitals by the Federal Government?

Dr. CRONIN. I do not think so.

ADVISABILITY OF EXTENDING LEGISLATION

Mr. FERNANDEZ. I mentioned awhile ago the millions of dollars we were expending on the health of our livestock for the benefit of our economy; and in years gone by we gave millions and millions of acres of land to the railroad companies to develop the West. Now that it has been developed, I was wondering if the Federal responsibility, if such it was in those days of conservatism, has ceased and we should not continue the construction program that was started under the

Hill-Burton Act and that is necessary for the national welfare in the present era.

Dr. CRONIN. Mr. Fernandez, if you are asking me if I as an individual think the Hill-Burton Act should be extended and continued I can only base my opinion on what I think are the accomplishments of this act; and I would be emphatically in favor of the extension of the act because I think it is doing a great deal of good.

Mr. FERNANDEZ. Is it not also absolutely necessary? To do otherwise, with this increasing population in the years to come, would be to go right back to where we were before the Hill-Burton Act, with a tremendous deficiency in the hospitals of the country. And that would just lead to a big drive for socialization of medical services.

Dr. CRONIN. I think, Mr. Fernandez, the answer to your question lies in the fact that there have been 2,000 projects approved and they are approved in every State in the Union, and every State in the Union has accepted this program and is participating in it. None of them have withdrawn from the program or refused to participate in it. Every State in the Union, to the best of my knowledge, is in favor of continuing its participation in this program.

Mr. FERNANDEZ. I do not know whether you are familiar with this from your experience in dealing with the States or not, but I would like to know about it. My observation in my home State has been that because of this handling of the responsibility by the States they are much more satisfied and, amazingly enough, the Advisory Council has done such a good job that, notwithstanding the fact that there was considerable rivalry as to whose needs should be taken care of first, there has been no complaint as to how they have been taken care of in the final determination.

Dr. CRONIN. That is correct.

Mr. FERNANDEZ. Is that your experience in the other States, also?

Dr. CRONIN. That is our experience.

Mr. FERNANDEZ. That is all, Mr. Chairman.

Mr. BUSBEY. I do not think we should conclude the hearings this afternoon until I get in the record a few words of appreciation for the gentleman from New Mexico, because I must say that he is always on his toes and does a very good job of representing his State.

Mr. FERNANDEZ. Thank you, Mr. Chairman. I try to.

Mr. BUSBEY. But I think rather than let you express my pleasure over the program, it would be best to wait until the report is issued and take advantage of that method of expressing my pleasure.

Mr. FERNANDEZ. Well, I hope it will be done and I am sure it will be.

Mr. BUSBEY. Is there anything else?

Mr. FERNANDEZ. That is all, Mr. Chairman.

Mr. BUSBEY. The committee will stand adjourned.

30853—53—pt. 2——22

MONDAY, MARCH 30, 1953.

HOSPITALS AND MEDICAL CARE

WITNESSES

DR. G. HALSEY HUNT, ASSISTANT SURGEON GENERAL, ASSOCIATE CHIEF, BUREAU OF MEDICAL SERVICES
DR. JAMES R. SHAW, CHIEF, DIVISION OF HOSPITALS
RICHARD R. RANNEY, DIVISION OF HOSPITALS
DR. VANE M. HOGE, ACTING CHIEF, BUREAU OF MEDICAL SERVICES

SALARIES AND EXPENSES

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$31,546,150	$33,688,000	$35,224,000
Transferred from—			
"Salaries, expenses, and grants, National Cancer Institute, Public Health Service," pursuant to Public Law 375	125,000		
"Salaries, expenses, and grants, National Heart Institute, Public Health Service," pursuant to Public Law 375	100,000		
Adjusted appropriation or estimate	31,771,150	33,688,000	35,224,000
Reimbursements from non-Federal sources	623,649	731,500	745,000
Reimbursements from other accounts	6,970,919	4,575,100	4,330,000
Total available for obligation	39,365,718	38,994,600	40,299,000
Unobligated balance, estimated savings	−111,582		
Obligations incurred	39,254,136	38,994,600	40,299,000
Comparative transfer from—			
"Salaries, expenses, and grants, National Cancer Institute, Public Health Service"	262,360	195,000	
"Salaries and expenses, Public Health Service"	106,678	100,000	
"Commissioned officers, pay, and so forth, Public Health Service"	142,194		
Comparative transfer to "Salaries and expenses, Public Health Service"	−20,993		
Total obligations	39,684,375	39,289,600	40,299,000

NOTE.—Reimbursements from non-Federal sources above are for medical services provided to foreign seamen, voluntary addicts, and for dependent care and out-patient visits (42 U. S. C. 221); and from the proceeds of sale of personal property (40 U. S. C. 481 (c)).

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
Direct Obligations			
Appropriated funds:			
1. Operation of hospitals	$26,757,166	$27,329,520	$28,041,220
2. Operation of out-patient clinics and offices	3,501,778	4,376,000	4,275,300
3. Operation of health units	9,329	9,580	9,580
4. Coast Guard medical services	936,230	994,500	979,400
5. Development and coordination of nursing resources	92,136	90,000	90,000
7. Payments to Hawaii		500,000	1,182,300
8. Administration	649,974	683,400	646,200
Total appropriated funds	31,947,613	33,983,000	35,224,000
Reimbursements from non-Federal sources:			
1. Operation of hospitals	621,228	731,500	745,000
2. Operation of out-patient clinics and offices	2,421		
Total reimbursements from non-Federal sources	623,649	731,500	745,000
Total direct obligations	32,571,262	34,714,500	35,969,000
Obligations Payable Out of Reimbursements From Other Accounts			
1. Operation of hospitals	6,024,331	3,263,580	2,982,080
3. Operation of health units	308,588	330,420	330,820
6. Personnel detailed to other agencies	780,194	981,100	1,017,100
Total obligations payable out of reimbursements from other accounts	7,113,113	4,575,100	4,330,000
Total obligations	39,684,375	39,289,600	40,299,000

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Summary of Personal Services			
Total number of permanent positions	7,753	7,810	7,492
Full-time equivalent of all other positions	129	129	128
Average number of all employees	7,551	7,143	7,184
Average salaries and grades:			
General schedule grades:			
Average salary	$3,660	$3,689	$3,696
Average grade	GS–4.3	GS–4.3	GS–4.3
Crafts, protective, and custodial grades:			
Average salary	$3,008	$3,031	$3,037
Average grade	CPC–3.7	CPC–3.7	CPC–3.7
Personal service obligations:			
Permanent positions	$29,096,025	$28,702,354	$28,884,754
Part-time and temporary positions	1,051,679	952,700	948,400
Regular pay in excess of 52-week base	137,593	71,346	79,646
Payment above basic rates	944,096	860,500	840,300
Total personal service obligations	31,229,393	30,586,900	30,753,100
Direct Obligations			
Appropriated funds:			
01 Personal services	24,867,517	26,082,340	26,456,140
02 Travel	265,755	264,330	239,750
03 Transportation of things	185,669	153,500	148,410
04 Communication services	105,496	120,900	120,660
05 Rents and utility services	433,925	478,800	465,000
06 Printing and reproduction	84,256	71,680	67,060
07 Other contractual services	992,512	1,369,350	1,226,940
Services performed by other agencies	431,400	512,300	549,100
08 Supplies and materials	4,694,912	4,760,660	4,778,280
09 Equipment	520,924	274,500	534,520
11 Grants, subsidies, and contributions	17,275	518,800	1,200,800
13 Refunds, awards, and indemnities	3,872	2,800	1,800
15 Taxes and assessments	40,264	46,340	46,120
Subtotal	32,643,777	34,656,300	35,834,580
Deduct charges for quarters and subsistence	696,164	673,300	610,580
Total obligations payable out of appropriated funds	31,947,613	33,983,000	35,224,000

Obligations by objects—Continued

Object classification	1952 actual	1953 estimate	1954 estimate
Reimbursements from non-Federal sources:			
01 Personal services	$493,402	$589,980	$595,400
02 Travel	4,197	4,870	4,370
03 Transportation of things	3,190	3,500	3,420
04 Communication services	2,025	2,540	2,490
05 Rents and utility services	9,926	12,340	12,050
06 Printing and reproduction	1,458	1,540	1,410
07 Other contractual services	8,461	10,610	10,250
08 Supplies and materials	100,786	117,110	117,810
09 Equipment	14,980	5,880	12,910
15 Taxes and assessments	849	1,130	1,110
Subtotal	639,274	749,500	761,220
Deduct charges for quarters and subsistence	15,625	18,000	16,220
Total obligations payable out of reimbursements from non-Federal sources	623,649	731,500	745,000
Total direct obligations	32,571,262	34,714,500	35,969,000
Obligations Payable Out of Reimbursements From Other Accounts			
01 Personal services	5,868,474	3,914,580	3,701,560
02 Travel	44,086	24,800	20,580
03 Transportation of things	33,411	18,000	16,070
04 Communication services	20,387	11,960	10,550
05 Rents and utility services	96,587	55,060	48,250
06 Printing and reproduction	14,762	7,780	6,630
07 Other contractual services	84,141	49,040	42,710
08 Supplies and materials	968,069	538,630	487,910
09 Equipment	110,712	30,020	55,570
15 Taxes and assessments	8,730	5,730	5,170
Subtotal	7,269,359	4,655,600	4,395,000
Deduct charges for quarters and subsistence	156,246	80,500	65,000
Total obligations payable out of reimbursements from other accounts	7,113,113	4,575,100	4,330,000
Total obligations	39,684,375	39,289,600	40,299,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$3,840,266	$3,068,000	$5,097,000
Obligations incurred during the year	39,254,136	38,994,600	40,299,000
	43,094,402	42,062,600	45,396,000
Deduct:			
Reimbursements received	7,594,568	5,306,600	5,975,000
Adjustment in obligations of prior years	1,111,060		
Unliquidated obligations, end of year	3,068,000	5,097,000	5,238,000
Obligated balance carried to certified claims account	2,851		
Total expenditures	31,317,893	31,659,000	35,083,000
Expenditures are distributed as follows:			
Out of current authorizations	28,876,811	28,591,000	29,986,000
Out of prior authorizations	2,441,082	3,068,000	5,097,000

Mr. BUSBEY. The committee will come to order.

This morning we have under consideration the requested appropriation for fiscal year 1954 for "Hospitals and medical care" of the Public Health Service. Dr. Hunt, we would be happy to hear from you at this time.

GENERAL STATEMENT

Dr. HUNT. Thank you, sir.

Mr. Chairman and members of the committee, the Public Health Service is well known to the American people as the governmental agency which helps to protect them from epidemics at home and from

the importation of exotic diseases from abroad. What is less well known is that the Public Health Service has a sizable program of direct patient care, for various groups of people whom the Congress has from time to time declared to be eligible for medical care by the Federal Government. As Dr. Scheele pointed out in his testimony before your committee, the Public Health Service of today is a lineal descendant of the Marine Hospital Service which was set up under President John Adams in 1798 to take care of American seamen. That function has continued without interruption and American seamen are still our largest single beneficiary group. The other principal groups for whom we provide medical care are officers and men of the United States Coast Guard, officers of the Coast and Geodetic Survey, officers of the Public Health Service, Federal employees hurt at work who become beneficiaries of the Bureau of Employees' Compensation, patients with leprosy, and persons who are addicted to narcotic drugs.

As you can well imagine, there are some special problems in the treatment of these last two groups of patients. At Carville, La., we operate the National Leprosarium which is the only hospital in the United States designed especially for the care of patients with leprosy. At Carville we have not only a medical problem but more strikingly a social problem, because in many quarters the patients are looked upon as outcasts rather than simply as patients with a disease which, though unpleasant, is rather hard to transmit and which therefore is not particularly dangerous to other people. Leprosy in itself is not a killer, but our patients in Carville develop diabetes, heart disease, kidney ailments, mental and nervous disorders, just as do people in the general population. Our job is therefore complicated because we must provide the specialized skills and facilities to treat the disease itself and at the same time have available the manifold services of a general hospital. The treatment of leprosy, incidentally, is much more promising today than it was a decade ago, thanks to the introduction of the sulfone drugs which were first tried at Carville. These drugs are not a specific cure but they do hold the disease in check in the great majority of early cases and most patients nowadays are able to leave the hospital after a period of treatment.

Another set of problems is found in the two neuropsychiatric hospitals at Lexington, Ky., and Fort Worth, Tex., which were designed primarily for the treatment of persons addicted to narcotic drugs. Here again there is a long and specialized course of treatment. We must first remove the individual's physical dependence on the addicting drug and then try to liberate him from the psychological need, an effort which may require work therapy or vocational training or active treatment by a psychiatrist or a combination of two or more of these techniques. Here again we must provide general medical and surgical services since the patients cannot be referred elsewhere for the treatment of intercurrent illness.

The appropriation for "Hospitals and medical care, Public Health Service," which you are considering today provides for the support of the hospitals and outpatient clinics of the Public Health Service and for a number of other activities which are closely related to patient care. This is a complex budget and I believe that it will be most clearly presented if we first take up each activity separately, before considering the total figures shown on page 78.

OPERATION OF HOSPITALS

This activity supports the 18 hospitals of the Public Health Service, exclusive of the clinical center in Bethesda, which is primarily a research unit of the National Institutes of Health rather than a hospital. There are 13 general hospitals, 2 tuberculosis hospitals, 2 neuropsychiatric hospitals (Lexington and Fort Worth), and the leprosarium at Carville. In order to get a clear picture of the budget request for fiscal year 1954, it is necessary to review what has happened in fiscal year 1953 when we have had to make some drastic changes in our hospital operation. The budget for fiscal year 1953 assumed that we would receive reimbursement from the Veterans' Administration for care of their patients on the basis of an average daily load of 650 in the general and tuberculosis hospitals. After the fiscal year had begun, at the end of July 1952, the Veterans' Administration found that it could not support this figure and we were told that the number of veterans would be reduced to an average of 375. This involved a reduction of available funds for the operation of our hospitals by over $1 million. As a result, in order to live within the amount of money available in this fiscal year, it was necessary to convert four hospitals to outpatient clinics in September 1952 and to make savings in every other area of operation to the maximum degree. This was done by reducing staff in the 18 hospitals that remain open to a level that would be unsafe for permanent operation, by reducing inventory to an uneconomical level, and by postponing the purchase of necessary equipment to future years. In making comparison between fiscal year 1953 and fiscal year 1954, therefore, we should keep in mind the emergency situation existing in fiscal year 1953. The request for 1954 totals $31,768,300 or $443,700 more than 1953.

Funds for this project include the comparative transfer of $195,000 from the appropriation, "Salaries, expenses and grants, National Cancer Institute, Public Health Service." This relates to the operation of a special tumor service at the Public Health Service Hospital at Baltimore. The tumor service was established by the National Cancer Institute as a pilot demonstration program in 1938, the purpose being to show the value of having a specialized tumor service operating in conjunction with a general hospital. This point has now been well proven and it is proposed to take over the operation of this service as part of the normal function of the Baltimore hospital. The funds which have been supporting it are therefore transferred along with the function.

The bulk of the increase in the activity, "Operation of hospitals," $298,600, is for equipment and represents a return to approximately our average annual expenditure for this purpose during the last several years. It leaves untouched, incidentally, the backlog of nearly $3 million worth of equipment needed by our hospitals for maximum efficiency in operation, a figure developed by a survey by department in each of our hospitals. The position structure in our hospitals has been reduced by 318 positions, which have been vacant for most of fiscal year 1953, to take account of the closure of 4 hospitals and their conversion to outpatient clinics. Because of lack of funds in fiscal year 1953, we have had to leave many additional positions va-

cant this year and the requested increase of $124,400 for personal services would permit us to refill a number of these positions It would also provide 25 additional man-years for the followup program to obtain basic knowledge concerning the long-range effectiveness of the therapy being given to narcotic drug addicts and to provide a start toward an effective rehabilitation program to restore seamen, coastguardsmen, and Federal employees to productive work. A provision of the Supplemental Appropriation Act, 1953, gives all Federal officers and employees the right to live outside of Government stations and reservations if they so desire. It is anticipated that under this provision fewer employees will elect to take quarters and subsistence, now furnished in kind with corresponding salary deductions, and that cash expenditures will therefore increase by $80,000. Other minor changes in the various objects of expense produce the net increase in the activity, "Operation of hospitals," of $443,700.

OPERATION OF OUTPATIENT CLINICS AND OFFICES

This activity supports 22 full-time outpatient clinics where Public Health Service beneficiaries can be treated and provides for more than 100 contracts with practicing physicians to take care of our beneficiaries in areas where the load is so small that it would not be economical to have full-time clinics of our own. It also provides for emergency hospitalization of our beneficiaries in contract hospitals. The request for this activity is for a total of $4,275,300, a reduction of $100,700 below the 1953 estimate. The bulk of the reduction will be in contract hospitalization. There is an increase of $34,400 in personal services to provide fuller utilization of existing positions because of an expected increase of 34,750 patient visits.

OPERATION OF HEALTH UNITS

This activity provides for the operation of Federal employee health programs in the several Government agencies as authorized by Public Law 658, 79th Congress. The total estimate is $340,400, an increase of $400 over fiscal year 1953. Of this total, only $9,580 is a direct appropriation, representing the cost of the health units in the Federal Security Buildings, North and South, in Washington The remainder is received on a reimbursable basis for services provided to other Federal agencies. The Federal employee health program is literally a health program rather than a medical care program. It does provide some care for minor on-the-job illness but its primary function is to maintain health of Federal workers so that they will not lose time from their jobs because of illness.

COAST GUARD MEDICAL SERVICES

As the medical arm of the Coast Guard, the Public Health Service is called upon not only to provide medical care for Coast Guard officers and men at our own facilities but also to provide medical services for Coast Guard personnel aboard Coast Guard vessels and at the Coast Guard Academy and other large shore installations. The request is for $979,400, a decrease of $15,100 below fiscal year 1953.

DEVELOPMENT AND COORDINATION OF NURSING RESOURCES

This activity is directed toward the expansion of the Nation's manpower resources in the critically short field of nursing personnel. The Division of Nursing Resources aims to develop and to make available methods which can be used within or outside the service to help balance the nurse supply against the needs of patients for all types of care. It has assisted nursing and allied groups in 33 States to locate their most acute needs for nursing service and then to initiate remedial programs. Following such consultation, States have established new practical nurse courses, have passed practical nurse licensure laws, and have provided State scholarship aid for professional nurses. The Division has developed methods which individual hospitals can use in determining how to make the best use of the nursing personnel they have. It is also the unit within the service which compiles, analyzes, and interprets statistical data and trends of nursing for the guidance of the Surgeon General and makes the information available to professional groups and other Federal agencies. The request for 1954 is $90,000, the same amount that was available in fiscal year 1953, and represents the bulk of the second comparative transfer of $100,000.

PERSONNEL DETAILED TO OTHER AGENCIES

This activity provides for medical personnel who are detailed to other Federal agencies on a reimbursable basis. There is no expenditure under this activity of funds appropriated to the Public Health Service. The largest item here is for medical officers detailed to the Bureau of Indian Affairs to assist in the operation of their hospitals and medical care program. The total request for 1954 is $1,017,100, an increase of $36,000 over fiscal year 1953. This represents an increase in services performed by Public Health Service officers for which reimbursement will be due.

PAYMENTS TO HAWAII

Public Law 411, 82d Congress, approved June 25, 1952, provided for payment to the Territory of Hawaii for care and treatment of persons afflicted with leprosy. The amount requested in the budget for fiscal year 1954 is $1,182,300, an increase of $682,300 over 1953. The need for an increase of this magnitude is made apparent by the fact that the $500,000 allowed for fiscal year 1953 does not even cover the cost of operation of the first 6 months.

ADMINISTRATION

This activity provides for the professional and administrative direction of the programs financed under this appropriation. The amount requested in fiscal year 1954 is $646,200, a reduction of $37,200 to be accomplished primarily by delaying the filling of positions that become vacant.

RECAPITULATION

If we now recapitulate these 8 activities as tabulated on the lower half of page 78, we find that it takes $40,299,000 to finance them in 1954, an increase over 1953 of $1,009,400. This total requirement of $40,299,000 is derived from 2 sources, $35,224,000 from direct appropriation and $5,075,000 from reimbursements.

I am glad to be able to tell you that on the basis of further information received from the Territory of Hawaii after the present budget had been submitted, the total requirement for 1954 will be $1,082,000 instead of $1,182,300 as shown under activity 7 in the printed budget. With this change in our request, the total increase in appropriation which you see on page 78 should be reduced from $1,009,400 to $909,100.

If you have any questions, Mr. Chairman, we shall be glad to try to answer them.

SEAMEN'S MEDICAL CARE

Mr. BUSBEY. On page 1 of your prepared statement, Dr. Hunt, you referred to the American seamen as still the largest single beneficiary group. Do they get full medical care?

Dr. HUNT. If they come to our hospitals or clinics they are entitled to receive any service that we have. If they are not at our own hospitals or clinics they may receive a certain amount of care in emergencies, but we do not undertake to provide complete medical service for a seaman no matter where he may be in the country. If he cannot get to one of our own hospitals the best we can do for him is to give him care in real medical emergencies.

Mr. BUSBEY. If a seaman comes to one of your hospitals, say the one at Chicago, what admittance determination is made as to whether he needs medical care or not?

Dr. HUNT. He is first determined to be eligible. That may be by his presentation of a master's certificate, a certificate signed by the master of a vessel certifying that he has served on board ship as a seaman. It may be that he will not have a master's certificate and will present his continuous discharge book, which shows when he has served on board ship. Or, if he has neither document, we are entitled under the regulations to accept his own statement. That is not a sworn statement, necessarily, but it is a statement under penalty. We may accept his statement that he has had the requisite sea service.

If he is found to be eligible at the admitting desk he is then sent to one of the doctors in the outpatient department. If it is after hours he is sent to the officer of the day, or the officer of the day is called for a medical determination as to whether he is sick enough to require hospital treatment. If so, he is admitted to the hospital.

If he is found to have a minor illness which requires treatment but not necessarily hospitalization he would probably be given an appointment to come back. If it is during the day he would be sent to the outpatient clinic. At night he would be given emergency treatment and told to come back to the outpatient clinic the next day.

RELEASE OF PATIENTS

Mr. BUSBEY. If a man is admitted to the hospital in Chicago under the determination that he does need medical care, is there any attempt made on the part of those responsible for the administration of the hospital to see that he is released from the hospital at the earliest possible date after his condition has been remedied?

Dr. HUNT. Attempts are made; yes. Each chief of service is responsible for the patients on his service; the medical service, surgical

service, and so on. The medical officer in charge has the duty to keep in front of the chiefs of services the fact that the patients should be discharged when they no longer need hospitalization.

It is not a foolproof system. Occasionally patients are not discharged at the moment when they have reached the full benefit of hospitalization. I think the great majority of them are.

Mr. BUSBEY. What is the reason that they are not discharged when they reach the point where they no longer require hospitalization?

Dr. HUNT. There are various reasons. I think the most common one is that they still need care of some sort.

In my own experience in the hospitals, we have sometimes found it rather hard to discharge a man from the hospital who had no place to go and who might not have any established State residence so that he could receive domiciliary care from a State. I think most of these people who are kept in the hospital longer than is absolutely necessary for strict medical care are kept because they need care of some sort and there is no good place outside where they can receive it.

To be sure, that is not the primary function of the hospital, but it is done from a humanitarian point of view.

Mr. BUSBEY. In effect, that means that the hospital is turned into a rest home for some of these people.

Dr. HUNT. To the extent that people require only domiciliary care, yes. The percentage numbers are, I think, very small. A few cases certainly can be found in a number of our hospitals. We try all of the time to minimize it.

Mr. BUSBEY. If I am a patient in the hospital and the medical officer thinks I am able to leave the hospital, but I protest and argue that I should stay, what is done to get me out of the hospital?

Dr. HUNT. A great variety of techniques are used. Where we have social-service workers—which, unfortunately, is not true at all of our hospitals—they are a great help in this function, because they are able, in many instances, to make arrangements with State or local agencies to take over the responsibility. I am thinking now of the person who needs continuing care of some sort, even though he does not need active medical care in a hospital.

If the hospital, to follow that just a moment, has no social-service worker, the medical officer in charge, the chief of the Medical Service, or possibly other people, will try to perform a similar function of finding some way to make arrangements for the care of this person somewhere else.

The medical officer in charge of our Cleveland hospital 3 or 4 years ago was able to make arrangements to get 4 or 5 such patients out of the hospital who had been in the hospital for some time. At least two of them were blind. One or two were completely crippled. They needed almost complete domiciliary care. It took a great deal of correspondence. I think one of them was the responsibility of Alaska, and the hospital had a great deal of difficulty making an arrangement to get him out. But they finally succeeded.

Now, if a person does not need further care and just would like to stay around to get free board, he gets very short shrift. I have, myself, conducted a number of such people to the front door, told them they had to leave the hospital, that there was no reason for them to be in there, they had a place to go, and it was up to them to go out and take care of themselves.

So, I think the answer to your question is that it all depends on circumstances. With some we are pretty tough. With others we try to make some arrangement which will provide for the proper continuing care of the individual.

LENGTH OF HOSPITAL STAY

Mr. BUSBEY. What would you say the average stay of the patients in the marine hospitals would be compared to the national average in all hospitals?

Dr. HUNT. Our average length of stay overall, in 1953, in the general hospitals, is about 24 days—24.2 days. That includes, even though these are general hospitals, a certain number of patients with tuberculosis, who, of course, stay a long time. Eighty percent of the patients in the general hospitals stay less than 30 days. Of that group, the average stay is 12 days. The median stay of the whole group in the general hospitals is 12 days. That is somewhat higher than the average in civilian general hospitals, but the reason for that is that civilian general hospitals normally have a large eye, ear, nose, and throat department. The average length of stay in that department, on the outside, and in our hospitals, too, is shorter. It runs on the outside something over 4 days, I believe.

Mr. BUSBEY. But the fact that the outside general hospitals have eye, ear, nose, and throat departments would not account for all the differential between the Public Health Service general hospitals and the outside general hospitals.

Dr. HUNT. The other main difference is that outside hospitals usually have a large obstetrical service and on that service, also, there is a length of stay of about 4 or 5 days.

On the medical and surgical services, our length of stay is about the same as that of the outside hospitals. There was a study done by the New York Hospital Council, which was published within the last month. Of the principal New York City hospitals, the length of stay on the medical service was somewhere in the neighborhood of 15 days, and on the surgical service I think it was around 13 days, with which we compare favorably.

PAYMENTS FOR CARE

Mr. BUSBEY. Do any of these patients pay anything for their medical care?

Dr. HUNT. We have a number of pay patients. The foreign seamen are under obligation to pay. Most of that is carried either by their shipping companies or the consul of the country they come from.

Mr. BUSBEY. I had reference to our nationals.

Dr. HUNT. I beg your pardon. The American seamen do not pay; no, sir. That is specified in the law: that American seamen are entitled to medical care and hospitalization without charge at hospitals and facilities of the Public Health Service.

Mr. BUSBEY. Are there any special taxes levied on them or their employees to cover any part of this cost?

Dr. HUNT. Not directly. Until 1884 seamen paid directly into a fund for their hospital care. From 1884 to the early 1900's—I believe it was 1906—there was a tonnage tax which was earmarked for the

support of the hospitals. Since that time, although the tonnage tax has been continued, it has been divorced from the support of the hospitals.

Mr. BUSBEY. For what is that tax used?

Dr. HUNT. I do not know, sir. I believe it goes into general receipts, but we do not have direct information on that.

JUSTIFICATION OF SERVICE

Mr. BUSBEY. In your opinion, Dr. Hunt, are these seamen any more entitled to special care such as they receive in the marine hospitals than, let us say, the men working on a railroad?

Dr. HUNT. They are a migratory group. A seaman whose home is in New York ranges all over the world, and he is just as likely to be sick in New Orleans and San Francisco as in New York.

The origin of the special care for seamen in 1798 took account of the fact that no State was very happy to provide medical care for a seaman coming into it as a transient from another State.

There is one other factor, and that is that this right of seamen to have medical care in the Public Health Service hospitals has been, I am sure, in the background of all wage negotiations, so that I think the pattern of wage negotiations would have been different if they had not had this service. How much different it would have been, of course, one does not know. But both the shipping companies and the seamen's unions are keenly conscious of the value of this service to the seafaring groups.

Mr. HARLOW. Mr. Chairman?

Mr. BUSBEY. Mr. Harlow.

Mr. HARLOW. I was going to say that the merchant marine, also, in time of war becomes a very vital part of our armed services. It is essential, if we are going to have them in time of war, that we also have them in peacetime.

Mr. BUSBEY. I think we all are agreed that conditions in the United States of America have changed considerably since 1798.

Dr. HUNT. Without question.

Mr. BUSBEY. You made some reference to these seamen being migratory. What about our migratory farmworkers? Are they not in the same position?

Dr. HUNT. That is another very serious problem, Mr. Chairman. During the war attempts were made to provide medical service for them. Since the war, that has been discontinued. But they remain a serious social and health problem.

SOCIALIZED MEDICINE

Mr. BUSBEY. What is your opinion with respect to the question of whether the special treatment the seamen receive is a form of socialized medicine?

Dr. HUNT. I suppose one would have difficulty saying that it was not a form of socialized medicine. It is provided by the Government as a condition or part of their employment.

I can really speak only from the medical point of view. I think that from that point of view the seamen are getting excellent care for less money than the service would cost under any other system.

It is up to somebody else to determine whether or not it should be the policy of the Government to continue that activity. From the purely medical point of view, I think that we can keep our heads up.

Mr. BUSBEY. Why should not some formula be worked out where the seamen and employers would pay so much money into a fund?

Dr. HUNT. That could be done, Mr. Chairman. I again do not feel competent to speak to the fiscal and social and political and economic factors involved.

Mr. BUSBEY. To your knowledge, has anything ever been done to bring this issue to the attention of the proper legislative committee of Congress?

Dr. HUNT. I do not know, sir.

OTHER BENEFICIARIES

Mr. BUSBEY. What about these officers and men of the United States Coast Guard, officers of the Coast and Geodetic Survey, and officers of the Public Health Service?

Dr. HUNT. All three of those groups are members of the uniformed services and, therefore, come under the Career Compensation Act of 1949 so far as compensation is concerned. It is true in all of the uniformed services that medical care of the officers and men is furnished. We are simply in the same position as the others in that respect.

CARVILLE HOSPITAL

Mr. BUSBEY. How many people do you have at Carville who are no longer under treatment and could be released if they had some place else to go?

Dr. HUNT. In the neighborhood of 50.

Mr. BUSBEY. Out of how many?

Dr. HUNT. 374 as of January 14.

Mr. BUSBEY. What steps do you take to have the families or the States care for them or pay you for caring for them?

Dr. HUNT. We have made frequent efforts to get families to assume responsibility. Occasionally in a number of cases we have tried to get the State to assume responsibility. In the case of those who are still there, that effort has, of course, been unsuccessful, because they are still there.

We do from time to time get people out who have been there a long time and who are no longer in need of active treatment, but who up to that point have had no place to go.

Mr. BUSBEY. What is done to encourage their families or States to assume responsibility for caring for these 50 patients?

Dr. HUNT. Many of them are blind. Many of them have considerable crippling deformity of their hands and feet. Some of them still have ulcerations which have to be dressed. Most of them literally have had no place to go.

The States, in most cases, have no places which are suitable for these patients, largely because we cannot assure them that the patients are no longer any risk at all. Now, they are a pretty minor risk, but when a person has had leprosy and has a crippling deformity other people who are not familiar with the disease find it very hard

to imagine that the person still is not dangerous, and there is a terrific psychic block against getting them into any normal welfare situation or old folks' home or anything of that sort.

NEUROPSYCHIATRIC HOSPITALS

Mr. BUSBEY. Do the States send any patients to the two neuropsychiatric hospitals at Lexington, Ky., and Fort Worth, Tex.?

Dr. HUNT. We have no authority to receive committed patients. States may send patients. If they do they simply come to us as voluntary patients. So far as we are concerned, they are voluntary patients and they are not official patients of any State.

Mr. BUSBEY. And, because of that, I assume that the States do not reimburse the Public Health Service for their care?

Dr. HUNT. That is correct.

Mr. BUSBEY. Do you have legal authority to keep a patient until he is cured at these two hospitals?

Dr. HUNT. No, sir. You are speaking, I assume, of the voluntary patients. The prisoner patients obviously are in a different category.

Mr. BUSBEY. Yes, sir.

Dr. HUNT. The voluntary patients sign a statement that they will stay until discharged, but within a year or two after the opening of Lexington in 1935 a patient decided to change his mind and submitted an appeal to the United States judge in that district and was released on a writ of habeas corpus. In other words, the judge told us that such a statement could be revoked by the patient at any time. We, therefore, have no authority within our own organization or under our own act to keep voluntary patients to the end of their treatment.

Mr. BUSBEY. In your opinion, would such authority be desirable?

Dr. HUNT. Highly.

Mr. HARLOW. Mr. Chairman, may I interrupt to say that our act does contain that authority but it was declared unconstitutional by this judge to whom Dr. Hunt referred. The act itself says:

> No such addict shall be admitted unless he agrees to submit to treatment for the maximum amount of time estimated by the Surgeon General to be necessary to effect a cure.

PENDING LEGISLATION

Mr. BUSBEY. What would be necessary to give you the authority you feel is needed?

Dr. HUNT. There is a bill now before the Congress which would provide that the Public Health Service could accept, under certain circumstances, patients who were committed by the mental-health authorities of their State, and that the Public Health Service in receiving those committed patients could act in effect for the State and keep them until they were thought ready to return to outside life. That, of course, is on the basis of mental-hygiene laws and not criminal laws.

Mr. BUSBEY. If that bill were inacted by Congress, do you think it would overcome this difficulty and give you proper constitutional authority?

Dr. HUNT. We believe so; yes, sir.

DETERMINATION OF WHEN PATIENT IS CURED

Mr. BUSBEY. How do you know when a patient is cured at these two hospitals?

Dr. HUNT. There is no absolute criterion.

Let us take morphine as the addicting drug. We know that withdrawal from morphine will take 1 to 2 weeks. During that period the person is physically sick if he is not getting his drug. At the end of that time the body readjusts and the person is able to get along without gross physical illness if he does not get the drug. However, physiological tests show some changes in a former drug addict for at least 3 months. In other words, it takes at least 3 months for the physical change in the body to return to normal. We feel that a cure takes at least that long. We must get all the physiological changes taken care of. Then, from that point on, it is largely a matter of judgment in an individual case.

We have set 4½ months as the normal, minimum length of time for treatment in the hospital. That is based on rather intangible judgmental factors. It does appear that the longer you keep them the better chance you have of keeping them off drugs.

RETURN TO ADDICTION

Mr. BUSBEY. Do you have any check on the percentage of patients who are dismissed from these two hospitals as cured who return to the habit?

Dr. HUNT. We have good figures on the number who come back to the hospital. We started last year a small-scale spot check in New York City to try to determine first whether we could actually follow these patients, since they tend to come from pretty bad surroundings economically. They tend to have had at least borderline trouble with the law, if not more than that, because of their addiction, and for various reasons they are not easy to follow.

One of the problems is that under the law we cannot disclose the fact that a person is a drug addict or that he is in the hospital for treatment as a voluntary patient, so that we cannot get the help of local welfare agencies to do very much of that.

First, can we follow them? Second, if we can follow them, can we be sure as to whether they still are off drugs or whether they have gone back onto drugs?

We did, as I say, establish a small study in New York last year which is still going on. So far we have been able to follow about 600 patients.

One of the items in this budget was a request for money to expand that study, because it seems to us so very important to find out exactly the answer to your question. At the moment we have only indirect information and partial information as to the number of people who go back onto drugs after a course at Lexington or Fort Worth.

TREND IN USE OF NARCOTICS

Mr. BUSBEY. From what knowledge you have of the situation, would you say that the use of narcotics is more prevalent or less so at present than two or three years ago?

Dr. HUNT. As far as we can tell it is diminishing somewhat. It is not the acute problem it was when we were before you 2 years ago.

Mr. BUSBEY. To what do you attribute that?

Dr. HUNT. I do not know. We do not know what the factors are. There may be just as many drug addicts in the country as there were 2 years ago. They are not coming to us in such numbers. But we know we take care of only a fraction of the total number in the country. Unfortunately, we cannot answer your question because we simply do not know.

CONVERSION OF HOSPITALS TO OUTPATIENT CLINICS

Mr. BUSBEY. You stated that you have converted four hospitals to outpatient clinics. Are these hospitals now being used for anything else?

Dr. HUNT. At the moment they are not. We are trying to get other quarters for the outpatient clinics in three of those cities. If that is successful we would then cease to operate outpatient clinics at the present hospital buildings and declare those buildings surplus so that some other governmental or nonprofit agency could use them as hospitals.

Mr. BUSBEY. We just concluded hearings on the hospital construction program under the Hill-Burton Act, and the testimony was that there is a tremendous need for hospitals. I am wondering if these hospitals might not be put to use to help relieve this shortage, instead of their just standing idle.

Dr. HUNT. Just as soon as possible we will make arrangements for their use as hospitals by turning them over to someone who can use them in that way.

Mr. BUSBEY. That is contemplated?

Dr. HUNT. Yes, sir.

Mr. STEPHENS. Mr. Chairman, in that connection I think the doctor might tell you about what happened at our Louisville, Ky., hospital. I am not sure of the details, but it was one of those cases, I am sure, where that hospital is possibly being used now.

Dr. HUNT. It was turned over to the city of Louisville. It is being used now.

TUMOR CLINIC AT BALTIMORE HOSPITAL

Mr. BUSBEY. At the top of page 5 of your prepared statement you state:

> It is proposed to take over the operation of this service as part of the normal function of the Baltimore Hospital.

Just what is that service, Doctor?

Dr. HUNT. The tumor clinic, as it was originally called, was established at the Baltimore Hospital in 1938 to demonstrate the value of a tumor clinic within or in conjunction with a general hospital. For the first 10 years or so it was a distinct unit operated directly by the National Institutes of Health, and to all intents and purposes the hospital was simply giving it space. About 5 or 6 years ago it became obvious that in the 10 years of its existence the tumor clinic had proved

extremely valuable in the case of our beneficiaries with various types of tumors; cancers, sarcomas, various blood disorders, and so on.

At that time, specific action was taken to integrate it into the hospital, to make it a service of the hospital on essentially the same basis as the surgical service, the medical service, or any of the other principal services. They have 30 or 35 beds and operate now simply as an integral part of the hospital.

Mr. BUSBEY. This won't cost as much as a part of the normal activity of the hospital as it did when it was a pilot demonstration project; will it?

Dr. HUNT. All research elements have been taken into consideration and removed from this figure. This figure represents the contribution which the Cancer Institute has been making to the operation of the hospital. They have been putting in more money than this amount, but on a research basis. They are retaining that and will use that money to carry on research in the Clinical Center as part of their function there.

EQUIPMENT FROM CLOSED HOSPITALS

Mr. BUSBEY. In the first sentence of the second paragraph on page 5, you state:

> The bulk of the increase in the activity, "Operation of hospitals, $298,600," is for equipment and represents a return to approximately our average annual expenditure for this during the last several years.

What has happened to the equipment in the four hospitals that were closed?

Dr. HUNT. That has been utilized almost completely. Some of it was in poor shape and was so old that it was literally not worth the expense of transportation. Except for that, all of the equipment has been moved to other hospitals and is now in continued use. That has made only a very small dent in the overall backlog which, as you see in the next sentence, amounts to $3 million. We are that much below what would be a good level of equipment for economical operation.

We certainly have used all we could of the equipment in the closed hospitals.

MEDICAL AND VOCATIONAL REHABILITATION

Mr. BUSBEY. Farther down on page 5 you refer to an effective rehabilitation program to restore seamen, coastguardsmen, and Federal employees to productive work. There is a vocational rehabilitation program covering this group, is there not?

Dr. HUNT. The Office of Vocational Rehabilitation covers the vocational end of it. They do very little on the medical part of rehabilitation, which involves taking people who have been injured or ill and getting them physically in such shape that they can either go back to their old work or go back to some kind of productive work. It is in this latter group—those who have to go back to a new kind of work—that the vocational-rehabilitation people do the most of their work, where it is a matter of retraining or developing new skills where old skills have had to be given up and so forth. But they do very little in the medical-rehabilitation field.

DEDUCTIONS FOR QUARTERS AND SUBSISTENCE

Mr. BUSBEY. At the top of page 6 you say:

> It is anticipated that under this provision fewer employees will elect to take quarters and subsistence, now furnished in kind with corresponding salary deductions, and that cash expenditures will therefore increase by $80,000.

Does this mean that as much of the appropriation will be spent on quarters and subsistence, even though these items are not being furnished to employees?

Dr. HUNT. No, sir. There are corresponding adjustments in other parts of the budget. This is the place in the budget where we have to show the amount of anticipated reimbursements or deductions, and the amount of anticipated reimbursements or deductions for quarters and subsistence will be reduced by $80,000. This is not an increase in the total requirement, because it has been taken into account in the preparation of the parts of the budget dealing with physical plant and total subsistence.

AVERAGE DAILY PATIENTLOAD AND OUTPATIENT VISITS

Mr. BUSBEY. I notice you expect an increase of 34,750 patient visits at your outpatient clinics. Why?

Dr. HUNT. We are making an effort to keep people out of the hospitals, to treat patients as outpatients to the maximum possible extent rather than put them into the hospital for the borderline types of illness. This is an activity which we have been carrying on for several years. It is one reason why our average length of stay has dropped over the past few years. We are taking care of more patients outside the hospital wherever possible, doing the physical examination, laboratory work, and so forth before admitting them to the hospital. The result of that has been a buildup in the outpatient activity and a reduction in our length of stay in the hospital.

EFFECT ON NUMBER OF HOSPITAL CASES

Mr. BUSBEY. Is a comparable decrease shown in hospital cases?

Dr. HUNT. Our inpatient load has been diminishing ever since 1947. It is hard to separate the various factors that have gone into that. All we can be sure of is that during the last 2 or 3 years our inpatient load has diminished slightly, while our outpatient load has continued to rise.

Mr. BUSBEY. At the bottom of page 81 of your justifications you have a table entitled "Average Daily Patientload and Outpatient Visits," which shows the estimated average daily patientload for the hospitals for 1953 as 6,510 and estimated for 1954 as 6,485. This would mean a decrease in the average daily patientload of only 25.

Dr. HUNT. That is right.

Mr. BUSBEY. It is hard for me to understand why you would have an increase of 34,750 in outpatient cases and a decrease of only 25 in average daily patientload in the hospitals.

Dr. HUNT. That is because the total amount of work required is increasing. That is, the total number of patients. If we treated them all as inpatients rather than as outpatients, the estimate would show a rise rather than this slight drop. In other words, the problem of the

care of seamen is not static. It changes from year to year, and since 1950 we have been in a period, with the increase in shipping and so forth, of an increasing load from our seamen group particularly. So that this estimate represents a slight drop in the inpatient load and a noticeable increase in the outpatient load. The total load is increasing.

INCREASE IN OBLIGATIONS

Mr. BUSBEY. In the very last sentence of your statement I note that you say

> * * * the total increase in appropriation which you see on page 78 should be reduced from $1,009,400 to $909,100.

It appears to me that the increase in the appropriation is $1,241,000, even when taking into consideration the comparative transfers.

Dr. HUNT. Yes. That should have been "obligations" rather than "appropriation." It should read "the total increase in obligations should be reduced from $1,009,000 to $909,100."

FUNDS REQUESTED OF BUDGET BUREAU

Mr. BUSBEY. For how much did you originally request of the Bureau of the Budget?

Dr. HUNT. In direct appropriation, $39,886,000.

Mr. BUSBEY. Was there a B estimate in addition to that?

Dr. HUNT. That is included. The A estimate was $36,763,000, and the B estimate was $3,123,000.

NONREIMBURSABLE AND REIMBURSABLE PATIENT LOAD

Mr. BUSBEY. At this point in the record, without objection, we will insert the table on page 82 of the justifications.

(The matter referred to is as follows:)

Average daily patient load by beneficiary group

	Actual, 1952	Estimate, 1953	Estimate, 1954
All beneficiaries	6,957	6,510	6,485
Nonreimbursable	5,373	5,496	5,552
Seamen (American and Government)	2,661	2,706	2,740
Narcotic addicts	1,435	1,500	1,515
Patients with leprosy	[1] 409	[1] 412	[1] 412
Coast Guard	371	402	409
Bureau of Employees' Compensation	302	302	302
Other	195	174	174
Reimbursable	1,584	1,014	933
Veterans	1,243	643	568
Foreign seamen	115	122	121
Armed Forces	70	74	72
Immigration	32	33	33
Dependents	99	112	110
Other	25	30	29

[1] Includes an average of 2 patients in general hospitals.

Comparative statement of reimbursements for 1952, 1953, and 1954

	Actual, 1952	Estimate, 1953	Estimate, 1954
Veterans	$5,561,169	$2,742,811	$2,456,377
Foreign seamen	536,647	634,553	651,434
Armed Forces	203,221	228,198	233,126
Immigration	155,184	171,641	171,605
Dependents	63,410	71,540	70,262
Other	94,062	115,998	117,512
Outpatient visits	30,183	30,339	26,764
Total, operation of hospitals	6,643,876	3,995,080	3,727,080
Total, operation of health units	308,588	330,420	330,820
Total, personnel detailed to other agencies	780,194	981,100	1,017,100
Receipts from trade-ins	4,104		
Total reimbursements	7,736,762	5,306,000	5,075,000

Mr. BUSBEY. I notice that you have done some close estimating for 1954. On the basis of what facts do you estimate an increase from 402 to 409 Coast Guard beneficiaries and an increase from 1,500 to 1,515 in narcotic addicts?

Dr. HUNT. Those figures are the result of computations by our statisticians in cooperation with the statisticians of the Bureau of the Budge and represent the best estimate the two groups can make as to what these loads will be.

Mr. BUSBEY. I was under the impression you mentioned that the demand on the two narcotic hospitals was on the decrease.

Dr. HUNT. It is less now than it was 2 years ago. The estimate for 1954 of 15 patients more than in 1953 is a slight increase, but it still is far below the experinece of 2 years ago.

NONREIMBURSABLE SERVICES

Mr. BUSBEY. In the item of nonreimbusables shown in the table we just put in the record, are you required by law to give free medical care for each of those groups?

Dr. HUNT. We are required to give service without charge to seamen; we are required to give service without charge to addicts who are Federal prisoners. Addicts who are voluntary patients are required to pay a per diem rate if they can do so, and a small number do. Patients with leprosy are taken care of without charge under the law.

In the case of coastguardsmen, there are two types of care. Officers are charged a small amount which represents the bulk of their subsistence pay. They are charged $1 a day for food, which is what it costs to provide the raw food for the hospital patients. Enlisted personnel are not charged at all for treatment or hospitalization. There is no provision in law to charge patients of the Bureau of Employees' Compensation, since they are compensation cases of the Federal Government.

The "other" group represents a variety, many of which are seamen under the terms of the law and, of course, there is not provision to charge them. Public Health Service and Coast and Geodetic Survey officers would come under the same provisions as the Coast Guard.

PROVISIONS OF LAW

Mr. BUSBEY. Could you prepare for the record a brief summary of the laws applicable to each group?

Dr. HUNT. We will be glad to do so.

(The information requested is as follows:)

PUBLIC HEALTH SERVICE ACT

(Public Law 410, 78th Cong.)

SECTIONS AUTHORIZING MEDICAL CARE FOR DESIGNATED BENEFICIARIES

SEC. 301. (f) For purposes of study, admit and treat at institutions, hospitals, and stations of the Service, persons not otherwise eligible for such treatment.

CARE AND TREATMENT OF SEAMEN AND CERTAIN OTHER PERSONS

SEC. 322. (a) The following persons shall be entitled, in accordance with regulations, to medical, surgical, and dental treatment and hospitalization without charge at hospitals and other stations of the Service:

(1) Seamen employed on vessels of the United States registered, enrolled, and licensed under the maritime laws thereof, other than canal boats engaged in the coasting trade;

(2) Seamen employed on United States or foreign-flag vessels as employees of the United States through the War Shipping Administration;

(3) Seamen not enlisted or commissioned in the military or naval establishments, who are employed on State school ships or on vessels of the United States Government of more than five tons' burden;

(4) Cadets at State maritime academies or on State training ships;

(5) Seamen on vessels of the Mississippi River Commission and, upon application of their commanding officers, officers and crews of vessels of the Fish and Wildlife Service;

(6) Enrollees in the United States Maritime Service on active duty and members of the Merchant Marine Cadet Corps; and

(7) Employees and noncommissioned officers in the field service of the Public Health Service when injured or taken sick in line of duty.

(b) When suitable accommodations are available, seamen on foreign-flag vessels may be given medical, surgical, and dental treatment and hospitalization on application of the master, owner, or agent of the vessel at hospitals and other stations of the Service at rates fixed by regulations. All expenses connected with such treatment, including burial in the event of death, shall be paid by such master, owner, or agent. No such vessel shall be granted clearance until such expenses are paid or their payment appropriately guaranteed to the Collector of Customs.

(c) Any person when detained in accordance with quarantine laws, or, at the request of the Immigration and Naturalization Service, any person detained by that Service, may be treated and cared for by the Public Health Service.

(d) Persons not entitled to treatment and care at institutions, hospitals, and stations of the Service may, in accordance with regulations of the Surgeon General, be admitted thereto for temporary treatment and care in case of emergency.

(e) Persons entitled to care and treatment under subsection (a) of this section and persons whose care and treatment is authorized by subsection (c) may, in accordance with regulations, receive such care and treatment at the expense of the Service from public or private medical or hospital facilities other than those of the Service, when authorized by the officer in charge of the station at which the application is made.[1]

CARE AND TREATMENT OF FEDERAL PRISONERS

SEC. 323. The Service shall supervise and furnish medical treatment and other necessary medical, psychiatric, and related technical and scientific services, authorized by the Act of May 13, 1930, as amended (U. S. C., 1940 edition, title 18, secs. 751, 752), in penal and correctional institutions of the United States.

EXAMINATION AND TREATMENT OF FEDERAL EMPLOYEES

SEC. 324. The Surgeon General is authorized to provide at institutions, hospitals, and stations of the Service medical, surgical, and hospital services and supplies for persons entitled to treatment under the United States Employees' Compensation Act and extensions thereof. The Surgeon General may also provide for making medical examinations of—

[1] Subsec. (e) was amended by sec. 3 of Public Law 781, 80th Cong.

(a) employees of the Alaska Railroad and employees of the Federal Government for retirement purposes;

(b) employees in the Federal classified service, and applicants for appointment, as requested by the Civil Service Commission for the purpose of promoting health and efficiency;

(c) seamen for purposes of qualifying for certificates of service; and

(d) employees eligible for benefits under the Longshoremen's and Harbor Workers' Compensation Act, as amended (U. S. C., 1940 edition, title 33, chapter 18), as requested by any deputy commissioner thereunder.

SERVICES TO COAST GUARD, COAST AND GEODETIC SURVEY, AND PUBLIC HEALTH SERVICE

SEC. 326. (a) Subject to regulations of the President—

(1) commissioned officers, chief warrant officers, warrant officers, cadets, and enlisted personnel of the Regular Coast Guard, including those on shore duty and those on detached duty, whether on active duty or retired; and Regular and temporary members of the United States Coast Guard Reserve when on active duty or when retired for disability;

(2) commissioned officers, ships' officers, and members of the crews of vessels of the United States Coast and Geodetic Survey, including those on shore duty and those on detached duty, whether on active duty or retired; and

(3) commissioned officers of the Regular Corps of the Public Health Service, whether on active duty or retired, and commissioned officers of the Reserve Corps when on active duty or when retired for disability; shall be entitled to medical, surgical, and dental treatment and hospitalization by the Service. The Surgeon General may detail commissioned officers for duty aboard vessels of the Coast Guard or the Coast and Geodetic Survey.

(b) Subject to regulations of the President, the dependent members of families (as defined in such regulations) of persons specified in subsection (a), other than temporary members of the United States Coast Guard Reserve, shall be furnished medical advice and out-patient treatment by the Service at its hospitals and relief stations, and they shall also be furnished hospitalization at hospitals of the Service, if suitable accommodations are available, at a per diem cost to the officer, enlisted person, or member of a crew concerned. Such cost shall be at such uniform rate as may be prescribed from time to time by the President for the hospitalization of dependents of naval and Marine Corps personnel at any naval hospital, pursuant to section 2 of the Act of May 10, 1943 (57 Stat. 80).

(c) The Service shall provide all services referred to in subsection (a) required by the Coast Guard and shall perform all duties prescribed by statute in connection with the examinations to determine physical or mental condition for purposes of appointment, enlistment, and reenlistment, promotion and retirement, and officers of the Service assigned to duty on Coast Guard vessels may extend aid to the crews of American vessels engaged in deep-sea fishing.

INTERDEPARTMENTAL WORK

SEC. 327. Nothing contained in this part shall affect the authority of the Service to furnish any materials, supplies, or equipment, or perform any work or services, requested in accordance with section 7 of the Act of May 21, 1920, as amended (U. S. C., 1940 edition, title 31, sec. 686), or the authority of any other executive department to furnish any materials, supplies, or equipment, or perform any work or services, requested by the Federal Security Agency for the Service in accordance with that section.

PART D—PERSONS AFFLICTED WITH LEPROSY

SEC. 331. The Service shall, in accordance with regulations, receive into any hospital of the Service suitable for his accommodation any person afflicted with leprosy who presents himself for care, detention, or treatment, or who may be apprehended under section 332 or 361 of this Act, and any person afflicted with leprosy duly consigned to the care of the Service by the proper health authority of any State, Territory, or the District of Columbia. The Surgeon General is authorized, upon the request of any health authority, to send for any person within the jurisdiction of such authority who is afflicted with leprosy and to convey such person to the appropriate hospital for detention and treatment. When

the transportation of any such person is undertaken for the protection of the public health the expense of such removal shall be met from funds available for the maintenance of hospitals of the Service. Such funds shall also be available, subject to regulations, for transportation of recovered indigent leper patients to their homes, including subsistence allowance while traveling. When so provided in appropriations available for any fiscal year for the maintenance of hospitals of the Service, the Surgeon General is authorized and directed to make payments to the Board of Health of the Territory of Hawaii for the care and treatment in its facilities of persons afflicted with leprosy at a per diem rate, determined from time to time by the Surgeon General, which shall, subject to the availability of appropriations, be approximately equal to the per diem operating cost per patient of such facilities, except that such per diem rate shall not be greater than the comparable per diem operating cost per patient at the National Leprosarium, Carville, Louisiana.[1]

PART E—NARCOTICS ADDICTS

CARE AND TREATMENT

SEC. 341. The Surgeon General is authorized to provide for the confinement, care, protection, treatment, and discipline of persons addicted to the use of habit-forming narcotic drugs who voluntarily submit themselves for treatment and addicts who have been or are hereafter convicted of offenses against the United States, including persons convicted by general courts martial and consular courts. Such care and treatment shall be provided at hospitals of the Service especially equipped for the accommodation of such patients and shall be designed to rehabilitate such persons, to restore them to health, and, where necessary, to train them to be self-supporting and self-reliant.

VOLUNTARY PATIENTS

SEC. 344. (a) Any addict, whether or not he shall have been convicted of an offense against the United States, may apply to the Surgeon General for admission to a hospital of the Service especially equipped for the accommodation of addicts.

(b) Any applicant shall be examined by the Surgeon General who shall determine whether the applicant is an addict, whether by treatment in a hospital of the Service he may probably be cured of his addiction, and the estimated length of time necessary to effect his cure. The Surgeon General may, in his discretion, admit the applicant to a Service hospital. No such addict shall be admitted unless he agrees to submit to treatment for the maximum amount of time estimated by the Surgeon General to be necessary to effect a cure, and unless suitable accommodations are vailable after all eligible addicts convicted of offenses against the United States have been admitted. Any such addict may be required to pay for his subsistence, care, and treatment at rates fixed by the Surgeon General and amounts so paid shall be covered into the Treasury of the United States to the credit of the appropriation from which the expenditure for his subsistence, care and treatment was made. Appropriations available for the care and treatment of addicts admitted to a hospital of the Service under this section shall be available, subject to regulations, for paying the cost of transportation to any place within the continental United States, including subsistence allowance while traveling, for any indigent addict who is discharged as cured.[2]

(c) Any addict admitted for treatment under this section, including any addict, not convicted of an offense, who voluntarily submits himself for treatment, may be confined in a hospital of the Service for a period not exceeding the maximum amount of time estimated by the Surgeon General as necessary to effect a cure of the addiction or until such time as he ceases to be an addict.

(d) Any addict admitted for treatment under this section shall not thereby forfeit or abridge any of his rights as a citizen of the United States; nor shall such admission or treatment be used against him in any proceeding in any court; and the record of his voluntary commitment shall be confidential and shall not be divulged.

---

[1] The last sentence of sec. 331 was added and the previous sentence amended by Public Law 411, 82d Cong.

[2] The last sentence of subsec. (b) was added by sec. 5 of Public Law 781, 80th Cong.

TITLE V—MISCELLANEOUS

SEC. 502. * * * The Immigration and Naturalization Service shall reimburse the Surgeon General for the care and treatment of persons detained in hospitals of the Public Health Service at the request of the Immigration and Naturalization Service unless such persons are entitled to care and treatment under section 322 (a).

TEMPORARY PROVISIONS RESPECTING MEDICAL AND HOSPITAL BENEFITS

SEC. 710. (b) Subject to regulations of the President, lightkeepers, assistant lightkeepers, and officers and crews of vessels of the former Lighthouse Service, including any such persons who subsequent to June 30, 1939, have involuntarily been assigned to other civilian duty in the Coast Guard, who were entitled to medical relief at hospitals and other stations of the Public Health Service prior to enactment of this Act, and who are now or hereafter on active duty or who have been or may hereafter be retired under the provisions of section 6 of the Act of June 20, 1918, as amended (U. S. C., 1940 edition, title 33, sec. 763), shall be entitled to medical, surgical, and dental treatment and hospitalization at hospitals and other stations of the Public Health Service: *Provided*, That such persons while on active duty shall also be entitled to care and treatment in accordance with the provisions of section 322 (e) of this Act.

Class of patients	Legal and regulatory authority	
	Public Law 410, 78th Cong.	Public Health Service regulations
A. Direct beneficiaries of the Public Health Service:		
American seamen	322 (a) (1)	32.11.
Seamen:		
U. S. Army Engineer Corps	322 (a) (3)	32.46.
Water Division, U. S. Army Transportation Corps (ATS)	322 (a) (3)	32.46.
Tanker Transport Branch, U. S. Navy (civilian)	322 (a) (3)	32.46.
Mississippi River Commission	322 (a) (5)	32.51.
Fish and Wildlife Service	322 (a) (5)	32.56.
State school ships	322 (a) (3)	32.46.
Cadets on State training ships	322 (a) (4)	32.76.
Cadets at State maritime academies	322 (a) (4)	32.76.
Merchant marine cadets	322 (a) (6)	32.61.
Maritime Service enrollees	322 (a) (6)	32.61.
Coast Guard personnel	326 (a) (1)	31.2 (a).
Active: Regular and Reserve Corps.		
Retired: [1]		
Regular Corps.		
Reserve Corps when retired for disability.		
Coast and Geodetic Survey officers and crew members	326 (a) (2)	31.2 (b).
Active.		
Retired.[1]		
PHS commissioned officers	326 (a) (3)	31.2 (c).
Active: Regular and Reserve Corps.		
Retired:[1]		
Regular Corps.		
Reserve Corps when retired for disability.		
Personnel of former Lighthouse Service	710 (b)	31.11.
Active.		
Retired.[1]		
Dependents [2] of Coast Guard personnel	326 (b)	31.9 (a).
Active: Regular and Reserve Corps.		
Retired:		
Regular Corps.		
Reserve Corps when retired for disability.		
Dependents [2] of Coast and Geodetic Survey officers and crew members.	326 (b)	31.9 (b).
Active.		
Retired.		
Dependents [2] of PHS commissioned officers	326 (b)	31.9 (c).
Active: Regular and Reserve Corps.		
Retired:		
Regular Corps.		
Reserve Corps when retired for disability.		
PHS civilian field employees [3] injured or taken ill in line of duty	322 (a) (7)	32.81.
Federal employee beneficiaries of the Bureau of Employees' Compensation.[4]	324	32.6 (c) (4).
Quarantine patients [5] (communicable disease)	322 (c)	32.6 (c) (2).
Persons afflicted with leprosy [6] (Hansen's Disease)	331	32.86.
Narcotic addicts [7]	341	33.7.

See footnote at end of table.

Class of patients	Legal and regulatory authority	
	Public Law 410, 78th Cong.	Public Health Service regulations
B. Other patients eligible for care on a reimbursable or full-pay basis:		
1. Seamen employed on foreign-flag vessels	322 (b)	32.106.
2. Immigration and Naturalization Service patients	322 (c); 502	32.6 (c) (3).
3. Former relief employees of the Works Project Administration; Civilian Conservation Corps, National Youth Administration (beneficiaries of the Bureau of Employees' Compensation).	327	32.6 (c) (5).
4. Beneficiaries of the Veterans' Administration	327	32.6 (c) (5).
5. Beneficiaries of the Department of the Army	327	32.6 (c) (5).
6. Beneficiaries of the Navy Department (includes Navy and Marine Corps personnel).	327	32.6 (c) (5).
7. Beneficiaries of the Office of Vocational Rehabilitation	327	32.6 (c) (5).
8. Beneficiaries of the Bureau of Prisons	327	32.6 (c) (5).
9. Beneficiaries of the State Department (Foreign Service employees).	327	32.6 (c) (5).
10. U. S. Army Engineer Corps employees (not seamen)	327	32.6 (c) (5).
11. Beneficiaries of the National Guard	327	32.6 (c) (5).
12. Beneficiaries of the Department of the Air Force	327	32.6 (c) (5).
13. Beneficiaries of the Maritime Administration (War Risk Insurance beneficiaries).	327	32.6 (c) (5).
C. Persons not otherwise eligible for treatment:		
Patients admitted for special study purposes	301 (f)	32.6 (c) (1).
Patients admitted for emergency treatment	322 (d)	32.6 (a) (12).

[1] Elective medical or surgical treatment requiring hospitalization will be furnished only at hospitals operated by the Public Health Service. Dental treatment will be furnished to the extent of facilities actually available within the physical limits of the station where full-time dental officers are on duty; at other medical care stations the dental treatment shall be limited to emergency measures necessary to relieve pain.

[2] Hospitalization is furnished only at PHS hospitals and reimbursement is made to the Service at the rate of $1.75 per diem. Dental treatment shall be furnished to the extent of available facilities only at medical care stations where full-time dental officers are on duty.

[3] Dental treatment is limited to that which is necessary for allaying of pain and treatment of acute oral pathological conditions. Fillings, dentures, and other related services required as a result of treatment of the aforementioned conditions may be furnished within the limits of available facilities at the station, exclusive of contract services.

[4] All services must be authorized by the Bureau of Employees' Compensation; voucherable expenditures are payable by that agency.

[5] Services must be authorized by responsible representatives of the Division of Foreign Quarantine of the Public Health Service and voucherable expenditures are payable by that Division.

[6] Treatment is furnished only at the Carville, La., Hospital and for temporary periods at any other Service hospital which has suitable facilities for the accommodation of such patients.

[7] Treatment is furnished only at the Public Health Service hospitals at Lexington, Ky., and Fort Worth, Tex. Patients made direct application to those hospitals. Voluntary patients who are financially able, are expected to pay $5 per day while hospitalized.

Mr. BUSBEY. What would happen if Federal funds were not appropriated for the medical care of these groups?

Dr. HUNT. Possibly other people could have a more accurate idea of that than we. All we can say is that the seafaring group and shipping companies have, over a period of 150 years plus, come to feel that this is an integral part of their operation. And I think you would certainly have a pretty loud protest from those groups.

You can carry on from there better than I can, I think.

Mr. FERNANDEZ. Another result would be that you would have a very nice bit of surplus property.

COST OF FOOD FOR PATIENTS

Mr. BUSBEY. How much of the $5,020,800 requested for supplies and materials on page 81 of the justifications is for food?

Dr. HUNT. $2,689,381.

Mr. BUSBEY. Upon what cost per ration or patient-day was that figured?

Dr. HUNT. In the general hospitals, $1 a day; in the special hospitals, that is, the 2 tuberculosis hospitals and Carville, $1.15, and at

the neuropsychiatric hospitals, $0.88 a day, and at all of the hospitals for employees and guests, $1.

Mr. BUSBEY. How does that compare with the figures for 1953 and 1952?

Dr. HUNT. The total in 1952 was $2,788,460; in 1953 it was $2,750,100.

Mr. BUSBEY. Dr. Hunt, could you please prepare that for the record in table form showing the breakdown for the 3 years?

Dr. HUNT. We will certainly be glad to do that.

(The table referred to follows:)

Ration costs by type of hospital, including value of station-produced subsistence

Type of hospital	Type of rations	Number of rations	Average ration cost	Subsistence requirements
Fiscal year 1952 actual:				
General hospitals	Patients	1,477,015	$0.953	$1,407,595
Special hospitals	do	328,684	1.177	386,890
Neuropsychiatric hospitals	do	741,667	.819	607,176
All hospitals	Employees and guests	565,333	.953	538,586
Gross subsistence requirements		3,112,699	.945	2,940,247
Less:				
Farm produced				93,603
Supplies from decommissioned ships.				58,184
Net subsistence requirements				2,788,460
Fiscal year 1953 estimate:				
General hospitals	Patients	1,273,850	1.00	1,273,850
Special hospitals	do	332,150	1.15	382,000
Neuropsychiatric hospitals	do	770,150	.88	677,700
All hospitals	Employees and guests	498,225	1.00	498,225
Gross subsistence requirements		2,874,375	.985	2,831,775
Less estimated value of station produced goods.				81,675
Net subsistence requirements				2,750,100
Fiscal year 1954 estimate:				
General hospitals	Patients	1,255,600	1.00	1,255,600
Special hospitals	do	335,800	1.15	386,200
Neuropsychiatric hospitals	do	775,625	.88	682,500
All hospitals	Employees and guests	448,755	1.00	448,755
Gross subsistence requirements		2,815,780	.985	2,773,055
Less farm produced				83,674
Net subsistence requirements				2,689,381

COMPARISON OF MEDICAL AND VOCATIONAL REHABILITATION PROGRAMS

Mr. BUSBEY. I notice on page 83 of the justifications you mention the rehabilitation program that we discussed in connection with your general statement. You say you need $63,500 "to start this program." Is this another case of the camel getting its nose under the tent? In other words, will it cost 10 times that much in another couple or 3 years?

Dr. HUNT. This would certainly be less than the full amount required to do the full job in this area for our beneficiaries. I do not know how much less it is. This would be sort of a pilot program which would give us better information for the future as to what kind of people and how many people you would need at a given hospital such as Baltimore or Staten Island to do a reasonably complete job in rehabilitation of seamen, coastguardsmen, and BEC

cases, particularly. Those are the three groups we are most concerned about at that hospital. Then the results of that pilot effort would give us much better information as to what the total needs of the whole system would be.

Mr. HARLOW. It might even possibly be that if they did a good rehabilitation job, the total cost of operating the hospitals would be less.

Mr. BUSBEY. I just noticed the justification for the Office of Vocational Rehabilitation. It contains a request for fiscal year 1954 of $3,862,221 under the item of "Hospital and medical care, appliances and other physical restoration services." Would your program duplicate what the Office of Vocational Rehabilitation is trying to do with the millions of dollars it is requesting?

Dr. HUNT. As far as I know, they work almost entirely with the States and use this money for the care of people who have no other resources. They have worked with us a little bit at Lexington on the special problem of drug addiction, but there is no duplication, and what we are asking for here would be for the physical restoration of our own patients in our own hospitals, for which the Office of Vocational Rehabilitation has never done anything. Whether they could do it under their law I do not know, but the fact is they have not done it and they are not proposing to do it with the money they are asking for 1954.

Mr. BUSBEY. I am not passing judgment on the worthiness of this proposed pilot rehabilitation program, but as long as we have an Office of Vocational Rehabilitation I cannot help thinking of the advantages of confining such work to that one agency, especially in view of the fact that it is experienced in the rehabilitation field.

Dr. HUNT. Their work in the medical field is rather limited. They have kept pretty well to their title, which is "vocational rehabilitation," and while they do assist the States in providing some medical care and appliances, that has been very much the least part of their work as far as I know. Certainly they have not been able to give us appreciable assistance in the physical restoration of patients, which has to be accomplished before one can train them either for a new job or retrain them for their old job.

COOPERATION BETWEEN AGENCIES

Mr. BUSBEY. Yes. But they are requesting this money for hospital and medical care. Now, with the large amount that they are spending for that purpose in the Office of Vocational Rehabilitation, I cannot see why that agency cannot be called upon to explore the possibilities of this program.

Dr. HUNT. We have asked them for assistance, and they have given it to us with respect to Lexington.

Mr. BUSBEY. I have seen so many of these things start. An agency is established just for the purpose of exploring the possibilities of a program; it inaugurates a pilot study; the next year it requests a little more money; and, almost before one realizes it, he is faced with requests for large appropriations. In the interest not only of economy but also of effective results, it does seem to me that Vocational Rehabilitation ought to be called in on this program.

Dr. HUNT. We would certainly call them in for consultation. The question of support is somewhat different. I think they have taken the point of view that we are responsible for the medical care of Public Health Service beneficiaries, and physical restoration nowadays is considered as providing part of the medical care.

Mr. BUSBEY. Well, these other hospitals work in the physical restoration field, and they are charged with the responsibility of medical care, too.

Dr. HUNT. They have their State agencies which have to provide a certain amount of hospitalization and a certain number of appliances for the patients in a given State.

Mr. BUSBEY. This happens to be a Government agency, and I do not see why it cannot assist another Government agency as well as a State agency, if it is a necessary and worthwhile program.

PHYSICAL RESTORATION

Dr. SCHEELE. I would like to break my reluctance to testify, but I think this is not very clearly presented. Actually this does not apply to the program of the Office of Vocational Rehabilitation that has been discussed with Miss Switzer. This is not quite the type of operation they would be called upon to do. This is an effort to provide the quality of medical care and hospitalization which any patient going to a hospital would expect to receive.

We have not in our own hospitals developed rehabilitation as adequately as we should. The modern concept of rehabilitation now is pulling together the services of surgeons, orthopedic and other surgeons, internists, and others in an effort toward giving integrated care to patients. And at the level of funds proposed here, this does not provide the full range of rehabilitation: this does not include the furnishing of artificial limbs or some of the other things. We do have a physical therapy department; we have most of the facilities for doing rehabilitation, which is the ordinary care currently provided, but this is a matter of organizing along the lines of our 1953 concept of medical care, and actually there is no conflict here with the OUR medical program so that we could not get their assistance in this operation.

STAFF FOR REHABILITATION PROGRAM AND ADDICTION FOLLOWUP PROJECT

Mr. FERNANDEZ. Mr. Chairman, if I may interrupt at that point, I notice that the 25 additional man-years that are requested for this purpose are broken down under two subjects—the one we have been discussing and the followup system to obtain basic knowledge concerning the long-range effect of therapy being given to narcotics addicts.

Is it possible to break down those 25 additional man-years so as to tell the committee how many will be used on the first item and how many will be used on the second item?

Dr. HUNT. 15.6 man-years for the rehabilitation program and 9.4 man-years for the addiction followup project.

Mr. FERNANDEZ. What is the emphasis in the rehabilitation program; is it on seamen, Coastguardsmen, and Federal employees only, or does it contemplate rehabilitation of addicts also?

Dr. HUNT. No. This would primarily be built around the type of rehabilitation that needs physical restoration and, therefore, would apply to persons who had been injured or who had prolonged illness of other kinds rather than narcotic addicts as such.

Mr. FERNANDEZ. These two items are not interdependent; are they? In other words, the one does not depend on the other?

Dr. HUNT. No, sir.

Mr. FERNANDEZ. So the committee could leave out one and grant the other?

Dr. HUNT. They are quite separate projects.

NEED FOR OUTPATIENT CLINICS AND OFFICES

Mr. BUSBEY. Dr. Hunt, why do you need 22 full time outpatient clinics and over 100 outpatient offices, as shown at the bottom of page 84 of the justifications?

Dr. HUNT. Those determinations are made almost entirely on the basis of the need in a given place for services. We have hospitals in the cities where there is the greatest demand, the greatest need for our services. In other cities where the volume of beneficiaries coming for service is not so great but where it is still a considerable number, we have outpatient clinics, even as we have here in Washington. Those "outpatient clinics", in our terminology, are establishments staffed entirely by Public Health Service employees, and they are, if you wish, adjuncts of the nearest Public Health Service hospital.

Outpatient offices are simply the offices of private physicians who have accepted contracts with us to take care of beneficiaries, and that, of course, is done only in places where the number of beneficiaries is so small that it would not be economical to have a full-time operation of our own. The compensation of each of the private physicians operating an outpatient office for us is determined largely on the basis of the volume of work he does. Most of them are on annual contracts, and we negotiate, beginning the 1st of July of each year, a contract with each office. The compensation is based primarily on the amount of work he has done for us during the current year.

Mr. BUSBEY. I have the same question about these outpatient clinics as for the hospitals we discussed awhile ago: Why are the present beneficiaries any more deserving of special treatment than railroad workers or migratory farm workers?

Dr. HUNT. If we are going to continue to take care of beneficiaries, I think this is an economical way to do it—to have gradations of service through outpatient offices and outpatient clinics to hospitals.

LOCATION OF CLINICS

Mr. BUSBEY. Are most of those outpatient clinics located on rivers and at seaports?

Dr. HUNT. The large clinics are on the coast. The four largest are in New York City, Philadelphia, Washington, and Los Angeles—San Pedro, which is a dual clinic. The others are either on the seacoast or on large rivers or on the Great Lakes.

FARM OPERATIONS AT FOUR HOSPITALS

Mr. BUSBEY. There are rather extensive farm operations carried on at the hospitals at Fort Worth, Lexington, and Fort Stanton, and there is also a dairy operated at Carville. Why do you think it is necessary to carry on those commercial operations at these locations, Dr. Hunt?

CARVILLE HOSPITAL

Dr. HUNT. I will first take up the last one you mentioned, because we can give you a definitive answer.

At Carville for many years it was impossible to obtain pasteurized grade-A milk commercially. We therefore operated a dairy to assure our patients and staff of having good quality pure milk. That situation has now changed. Commercial milk of good quality is available from Baton Rouge, and as of this spring we are discontinuing the dairy at Carville.

LEXINGTON AND FORT WORTH

With respect to the other 3, we have 2 situations. At both Lexington and Fort Worth, the farm operation is part of the therapy. Taking care of the addict patients involves getting them back into some sort of useful occupation and particularly getting them to do something to occupy their minds and giving them a sense of accomplishment. In both of those hospitals, therefore, the farm operation is primarily therapeutic. As a byproduct, of course, it does furnish a considerable portion of the meat and vegetables used at the hospitals, but that is distinctly not its primary function.

FORT STANTON

At Fort Stanton, there again, historically, there was a problem in getting adequate supplies of first quality meat and milk, and there are 2 herds, 1 for beef and 1 for milk. The dairy herd and the beef herd were developed and are still carried on. It is questionable whether that operation should be continued. We do have 25,000 acres of land there which Mr. Fernandez can tell you will support a thousand head of cattle, approximately. We are grazing approximately 1,000 cattle on that reservation.

Mr. BUSBEY. Let us take Fort Stanton. I might say I am particularly interested in situations of this kind—so much so that recently I introduced a bill in the House, House Joint Resolution 184, which, if enacted, would set up a commission similar to the old Hoover Commission established to study the operations of Government, but this commission would study Government competition with private taxpaying enterprise. I have already discovered some very amazing things on my own. While I had listed approximately 75 agencies of the Government that were in direct competition with private taxpaying enterprise, many other situations have been called to my attention by people all over the country—situations that I did not even dream existed. And while it might have been true that in the early days there was a need for this operation at Fort Stanton, I do not believe the need exists today. Does it, Dr. Hunt?

Dr. HUNT. I do not believe so; no, sir. And I may say we have seriously considered doing the same thing at Fort Stanton that Dr. Shaw has done at Carville; namely, doing away with the farm operation, the beef and dairy herds.

Mr. BUSBEY. Along this line, I might also add to the record that I was very happy to see that President Eisenhower and Secretary of Commerce Weeks are formulating plans to sell the Inland Waterways Corporation. In 1947 and 1948, when I was a member of the Interstate Commerce Committee of the House, I tried to set the wheels in motion to sell it but was unsuccessful. The Inland Waterways Corporation is one of those agencies of Government that were set up during World War I with an explicit provision of law that it was to be liquidated and the Government removed from the barge business at the end of World War I. And here it is still in existence, and the Congress has been requested to appropriate millions upon millions of dollars through the years to make up the deficit of this operation, so much so that I think the total appropriations would amount to 5 or 6 times the total assets of the corporation.

I am very happy to hear you say that the farm operations at Carville and at Fort Stanton are in the process of being terminated, in view of the fact that the original needs no longer exist.

Mr. FERNANDEZ. He did not quite say that about Fort Stanton.

DIFFERENT METHODS OF FINANCING FARM OPERATIONS

Mr. BUSBEY. He said that it was contemplated. Perhaps my statement was based just a little on wishful thinking, but I hope not.

Why have the farm operations at Carville and Fort Stanton been financed from the appropriations, while at Lexington and Fort Worth the operations are carried on under a working fund?

Dr. HUNT. That is largely historical, I believe. The hospitals at Lexington and Fort Worth were under a different division for the first 14 or 15 years of their existence— the old Division of Mental Hygiene—and the farm operations there were set up under a working-capital fund, I think chiefly because of the fact they were considered as a therapeutic adjunct and should be handled separately.

Mr. Harlow can give you more of that history than I can, I am sure.

At Fort Stanton and Carville, the operations have been carried on as part of the hospital functions, primarily because they were adjuncts to provide food for the hospital patients.

FINANCIAL OPERATIONS, FISCAL YEAR 1952

Mr. BUSBEY. Did these operations make or lose money during the 1952 fiscal year?

Dr. HUNT. The working-capital fund has usually made a profit. In 1952 the actual cost of operation did exceed the income by $9,000. That was because of the pay raise which took place that year and also because of a reorganization which had a temporary adverse effect on sales.

Of course, bookkeeping is a little difficult in these, because they sell their produce to the hospital at the going market price, so that the profit and loss depends partly on what the market happens to be doing at any given time. By and large, the working-capital fund has shown a considerable increase in the 16 or 17 years since it was established.

NUMBER OF ACRES

Mr. BUSBEY. How many acres of land are involved in these four operations?

Dr. HUNT. We can supply that for the record.

Mr. BUSBEY. If you will, please.

(The information referred to is as follows:)

Number of acres utilized in support of beef and dairy cattle by hospital

Hospital:	Acres
Carville	137
Fort Stanton	25,000
Fort Worth	1,265
Lexington	814
Total	27,216

TAX CALCULATIONS

Mr. BUSBEY. In figuring your profit-and-loss statement, do you take into consideration the taxes that a private individual would pay?

Dr. HUNT. Under the working-capital fund?

Mr. BUSBEY. Under both forms of financing.

Dr. HUNT. Not directly. In the working-capital fund, we use the going-market figure, which presumably does include the provision for taxes and profits, but in the others we simply make an estimate at Carville and Fort Stanton of the value of the produce—the meat, vegetables, and so forth—that go to the hospital. That is on a rather crude overall basis in those two places, because it is all within the same fund.

Mr. BUSBEY. But you do not have a specific item of taxes included in the cost?

Dr. HUNT. No, sir.

Mr. HARLOW. We do not figure taxes at all in the cost, Mr. Chairman. I think about 5 or 6 years ago we turned back to the Treasury $50,000 out of this working-capital fund from the surplus that had been built up in it.

BEEF CATTLE

Mr. BUSBEY. How many beef cattle do you own?

Dr. HUNT. We will have to supply that for the record. Would you prefer to have an estimate now or let us supply that later?

Mr. BUSBEY. You can supply it for the record.

(The information is as follows:)

Number of beef cattle at Fort Stanton, Fort Worth, and Lexington

Hospital:	Beef cattle
Fort Stanton	957
Fort Worth	66
Lexington	229
Total	1,252

Mr. BUSBEY. How much therapeutic value to patients is there in the beef-raising operation?

Dr. HUNT. Quite a good deal. At both Lexington and Fort Worth the farm operation as a whole, which includes beef raising, is of considerable value to the patients. It is hard to measure, but we are perfectly convinced that that type of activity—getting out and having to do a regular job every day and, in the case of the farm operation, being outdoors and doing a certain amount of physical work is of value. I quite agree that we cannot measure it objectively and say it has so many units of therapeutic value, but it certainly is of considerable value.

Mr. BUSBEY. Even assuming that the farm operations break even, is it not best to let private enterprise do the job, unless there is clearly and definitely a considerable therapeutic value not otherwise available to the patients?

Dr. HUNT. With that latter proviso, I would not disagree with your statement at all.

REIMBURSEMENTS FROM VETERANS' ADMINISTRATION

Mr. FOGARTY. Doctor, what happened to the reimbursements from the Veterans' Administration in this past year?

Dr. HUNT. We entered the year expecting to have an average daily patientload of 650 veterans in our general and tuberculosis hospitals. The action of the Veterans' Administration late in July, which they were forced to take because of their own shortage, reduced the average number of veteran patients in our hospitals each day to 375. The reimbursement that we get for a patient per year is something over $5,000; so that that reduction of 100 patients sent to us by the Veterans' Administration on the average means a loss of $500,000 plus a year. This was a loss of 275 veterans; so that our anticipated income was reduced by that amount. Our anticipated income was reduced by well over $1 million.

Mr. FOGARTY. What happened to these veterans?

Dr. HUNT. I am afraid we do not really have the answer to that within our own knowledge, Mr. Fogarty. We know we had to close a hospital at Mobile which was averaging 45 or 50 veterans and that we have had many complaints from the veterans in the Mobile area that they were not able to get hospitalization as easily as they had in the past.

I think one can probably say the waiting list for Veterans' Administration hospitals became somewhat longer.

PATIENTLOAD AND CAPACITY AT FORT WORTH AND LEXINGTON

Mr. FORGARTY. Is Lexington filled at the present time?

Dr. HUNT. As of March 18, there were 1,340 patients in Lexington. The constructed capacity of Lexington is 1,400, and they have crowded in an additional 38 beds, so that they have 1,438 beds set up. They have, therefore, on March 18 a margin of 60 beds within their constructed capacity or 98 beds within their total number of beds set up.

Mr. FOGARTY. What about Fort Worth?

Dr. HUNT. Forth Worth on the same day had 835 patients with a constructed capacity of 762 and set up beds of 976.

COMPOSITION OF PATIENTLOAD

Mr. FOGARTY. Are the patients at Forth Worth and Lexington all narcotics?

Dr. HUNT. They are all neuropsychiatric patients. In Lexington the great majority are addicts, 1,259 out of the 1,340. In Forth Worth the addicts account for 344 out of the 835.

Mr. FOGARTY. What are the others at Forth Worth?

Dr. HUNT. At Forth Worth there are 2 other large groups of patients with mental illness, 271 veteran patients sent to us by the Veterans' Administration, and 202 seamen, plus 16 coastguardsmen, and a scattering of others.

Mr. FOGARTY. We had thought a couple of years ago that by strengthening the law in regard to jail sentences for illegal dispensing of these drugs we could keep a lot of the drugs off the market. As you know, we did pass a pretty strict law a couple of years ago, making it mandatory to impose jail sentences on first, second, and third offenders. Has that had any effect in reducing the number of cases?

Dr. HUNT. It is possible that is one of the factors. It is very hard to be sure just what the factors are.

Mr. FOGARTY. I remember a couple of years ago you had a waiting list at Lexington.

Dr. HUNT. That is correct.

Mr. FOGARTY. As I remember, you could not even take care of the teen-agers who were being sent to you.

Dr. HUNT. I think we were able to take care of all first admissions at all times. That is my memory. We did have waiting lists for women and for repeat admissions of men. The fact is we are getting fewer patients by a little bit than we got 2 years ago. Just what are all the factors that go into that, it is pretty hard to say.

Mr. FOGARTY. And most of those people you are required to take care of free of cost under the law?

Dr. HUNT. Oh, absolutely.

Mr. FOGARTY. So if we refuse to appropriate any money, we, in effect, will be repealing the existing law of Congress?

Dr. HUNT. That is correct.

Mr. FOGARTY. The same question might be asked about the Veterans' Administration. If we do not appropriate any money for the hospitalization of veterans, that is what would happen?

Dr. HUNT. Yes, sir.

Mr. FOGARTY. A coastguardsman is a veteran; is he not?

Dr. HUNT. He becomes a veteran after he leaves the Service. They have full military rights.

VETERANS' REHABILITATION PROGRAM OF VETERANS' ADMINISTRATION

Mr. FOGARTY. What about the rehabilitation program of the Veterans' Administration? How does that compare with your requests for this pilot program?

Dr. HUNT. I do not have the figures on it. I believe it is many times larger.

Mr. FOGARTY. It is doing what you would like to do in rehabilitating the patients in these hospitals?

Dr. HUNT. Yes. Dr. Howard Rusk, immediately after the war, was called in as a consultant to the Veterans' Administration and established a large activity which has done a great deal of work and a great deal of good in rehabilitating veterans who have been hospitalized in their hospitals.

Mr. FOGARTY. Did you make a study of that program to determine whether or not you should enter the same field?

Dr. HUNT. We are rather familiar with it; yes, sir.

Mr. FOGARTY. Has it done any good?

Dr. HUNT. A great deal.

Mr. FOGARTY. Has it been beneficial in the way of keeping veterans out of hospitals or of getting them out more quickly?

Dr. HUNT. Dr. Rusk was able to take 1 group of patients—my recollection is there were some 60 or 80 in the group, patients who had been hospitalized for many years and were considered to be hopeless cases—and by the use of modern rehabilitation techniques he was able to get all but a few of them so that they could get up out of bed and take care of their personal needs. And I believe somewhere around half of them were able to leave the hospital—maybe more than half. It was a very dramatic demonstration of what can be done with people who are considered hopelessly crippled or ill.

Mr. FOGARTY. Did it save the Veterans' Administration any money?

Dr. HUNT. It saved them the cost of hospitalizing those people for another X number of years until they died, because before Dr. Rusk started there was no hope of ever getting those people out of the hospital.

COMPARISON OF VETERANS' ADMINISTRATION AND PUBLIC HEALTH SERVICE HOSPITALS

Mr. FOGARTY. How do your hospitals compare as to facilities with the veterans' hospitals?

Dr. HUNT. We have, of course, many fewer hospitals. We do not have the same domiciliary situation that the veterans have. They operate a certain number of strictly domiciliary institutions and we do not have that at all. In our general hospitals we take care of very much the same type of patient that they do.

Mr. FOGARTY. You give the same type of care?

Dr. HUNT. We think it is at least as good. We are quite proud of the care we give our patients. We do it for less money than any of the other services, from what information we have been able to get concerning the veteran or military hospitals. It is hard to make comparisons, and I am not suggesting any strict comparisons, but that statement is true to the best of our knowledge.

PUBLIC HEALTH SERVICE HOSPITALS

Mr. FOGARTY. What was the breakdown of hospitals? There were two TB hospitals——

Dr. HUNT. Two neuropsychiatric, Carville, and 13 general hospitals

Mr. FOGARTY. Where are the two neuropsychiatric hospitals?

Dr. HUNT. Those are hospitals at Lexington and Fort Worth.

Mr. FOGARTY. Why do you call them neuropsychiatric?

Dr. HUNT. They were established as narcotic farms, primarily to give psychiatric care to drug addicts. As time went on, other types of psychiatric patients were sent there because they are suitable for the care of psychotic patients or other seriously disturbed mental patients.

As I said a few minutes ago, Lexington has only a small fraction of such patients. At Fort Worth over half of the patients are other than addicts, hospitalized for other kinds of mental illness.

FACTORS IN SIZE OF PATIENTLOAD

Mr. FOGARTY. Your patientload is based mainly upon size of Federal employment, the potential in the Coast Guard, and the activity of the merchant marine?

Dr. HUNT. Yes, sir.

Mr. FOGARTY. You have no control over that at all, do you?

Dr. HUNT. That is correct.

Mr. FOGARTY. That is controlled essentially by Congress, when it determines how many shall be in the Coast Guard and how far we are going to go in the merchant marine and maritime field, and how many employees are to be hired by the Federal Government?

Dr. HUNT. Yes, sir.

Mr. FOGARTY. So, you have no control over the patientload?

Dr. HUNT. No, sir.

SEAMEN'S HOSPITALS

Mr. FERNANDEZ. Doctor, in your statement you say there are 18 hospitals. You described all but 13 of them. How many of those 13 are seamen's hospitals?

Dr. HUNT. The 13, Mr. Fernandez, are all general hospitals, and all of them have a preponderance or at least a proportion of seamen in their hospital population. Seamen are eligible for admission to any of them.

Mr. FERNANDEZ. You mentioned four which have been converted into outpatient clinics. Which are they?

OUTPATIENT CLINICS

Dr. HUNT. The former hospitals at Portland, Maine; Kirkwood, Mo., just outside of St. Louis; Mobile, Ala.; and San Juan, P. R.

ADMISSION OF PAY PATIENTS

Mr. FERNANDEZ. What is the policy in these general hospitals with respect to the pay-admission of persons other than seamen and other beneficiaries? Do you take any at all?

Dr. HUNT. We do not take any patients except those who have been declared to be beneficiaries by act of Congress. We take care of veterans, who are not our direct beneficiaries, upon request of the Veterans' Administration. We take care of foreign seamen as beneficiaries specified by the law on a pay basis, but we do not take care of the aver-

age citizen who comes along who would just like to come in and pay for hospital care.

DISPOSITION OF SURPLUS HOSPITALS AND OTHER MEDICAL PROPERTIES

Mr. FERNANDEZ. Some of these hospitals, if declared surplus, could not be used by a community close by—and I have in mind Fort Stanton—unless the community also had some of the patients which you already have in the hospital. Has any thought been given to the possibility of turning some of those hospitals over to county, State, church, or other organizations or agencies, and giving them the right to treat patients such as seamen now treated there by the Government, for which the Government would reimburse the hospital?

Dr. HUNT. There is a regular procedure for the disposition of hospitals or other properties in the health field which become surplus to the needs of the Government. If we find that a hospital is surplus to our needs, such as the one at Kirkwood, to take that as an example, as soon as we are able to make arrangements for other quarters in the city of St. Louis for an outpatient clinic we will declare the hospital at Kirkwood surplus to the needs of the Public Health Service.

PRIORITIES

When the Public Health Service has declared it surplus, the other parts of the Federal Security Agency would have a chance to use it if they had need for it.

If no other unit of the Agency needs it, it would be declared surplus to the Agency. Then it would be offered to the military and to the Veterans' Administration.

If they do not need it, it would be offered to the other departments of the Federal Government.

If, finally, no part of the Federal Government needs it, it would be declared surplus to the needs of the Federal Government and it would then be available for transfer to a State, to a smaller political subdivision, or to a charitable or other nonprofitable organization, including a church organization.

Mr. FERNANDEZ. Is there also a priority schedule, below the Federal priorities?

Dr. HUNT. I am not too sure about the priority after it becomes surplus to the needs of the Federal Government. I think a State would have a pretty high priority in that respect.

TRANSFER PROCEDURE

Mr. FERNANDEZ. Would the State or county or other local organization have to purchase it, or could it be transferred to them?

Dr. HUNT. It could be transferred to them.

Mr. FERNANDEZ. How would you do it? How did you transfer the Louisville, Ky., hospital to Louisville?

Dr. HUNT. That was held by the General Services Administration, Public Buildings Service, for some time. Actually the Public Health Service does not itself own any of these hospitals. They are owned by the Public Buildings Service and we are simply tenants.

That introduces another complication, because once we declare a hospital surplus to the needs of the Public Health Service it be-

comes a matter for the Public Buildings Service to handle in its routine manner.

Mr. FERNANDEZ. Is there any way at the present time whereby, without declaring a hospital surplus, arrangements could be made to have it transferred to the State or county but used by the Federal Government on a reimbursable pay basis?

Dr. HUNT. I do not know of any mechanism by which that could be done, Mr. Fernandez. Possibly it could. We would have to check it with the other authorities and the lawyers.

Mr. FERNANDEZ. I am very much concerned with what is going to happen to Fort Stanton in view of the fact that it is not being fully utilized. I am afraid that one of these days you might want to declare it surplus. I was wondering if it were possible to give that some consideration and see if such arrangements could be made if that time ever comes.

Dr. HUNT. One of our problems, of course, is that we do not declare hospitals surplus until we do not any longer have an effective need for them.

Mr. FERNANDEZ. I realize that. That is why I was wondering whether or not such arrangements could be made, even though you do not declare it surplus. Or perhaps it could be declared surplus with an understanding that the patients there now would remain there and the State would be reimbursed for their keep.

Dr. HUNT. We would certainly have to get advice on that. I cannot answer it offhand.

Mr. HARLOW. I am almost certain it would not be possible to make that kind of an arrangement without special legislation, Mr. Fernandez.

Mr. FERNANDEZ. I had in mind the fact that the patients at Fort Stanton want to stay there, because of the excellent climatic conditions, dry mild climate, so beneficial to tuberculars. Second, the State or county probably would not be able to fill it if they were to use it exclusively for the general public.

Do you have in these hospitals seamen who are there only because of illness, if illness it is, resulting from old age?

Dr. HUNT. We have no authority to take care of retired seamen as such. We have authority to take care of illness starting during the time a person is an active seaman.

Now, there is a certain borderline group, including some of those the chairman was speaking of earlier in the morning, who are not clearly in need of the further active medical treatment but who are not clearly able to go out and resume their occupation, either because of advancing years or for other reasons. So some of those people have from time to time stayed in our hospitals for varying periods of time. We make every effort to minimize that sort of prolonged treatment. Sometimes it has been hard to avoid it, particularly with patients with an illness like tuberculosis, which is a long-term proposition anyway. Once we accept a person with tuberculosis we have taken on a course of treatment that is going to last at least a year in most cases, and frequently longer.

Mr. FERNANDEZ. Those are the people I had in mind. Irrespective of your legal authority in this area, as a practical proposition you just cannot turn them out. A good many of the seamen are sort of wanderers who have no families and they get old, and particularly

when they have been afflicted with tuberculosis, to begin with, there is just no place they can go. I was wondering about how many you had of that category in the various hospitals.

Dr. HUNT. We do not get any figures that would give us a breakdown of that, Mr. Fernandez. We would have to do a census patient by patient to find out, because there is no objective measure of which patients would fall into the category you described. We would simply have to go and look at each one individually.

PER DIEM RATE AT CARVILLE HOSPITAL

Mr. FERNANDEZ. What is the per diem patient rate at Carville Hospital?

Dr. HUNT. During the period July to February of this current fiscal year the rate has been $11.14, sir, at Carville.

Mr. FERNANDEZ. Can you tell us what goes into the determination of that rate?

Dr. HUNT. The items that are included in this computation are the salaries of all of the people in the hospital, including doctors and dentists, who have to do with in-patient care; the total cost of supplies for the hospital; the total cost of foods; and a small category of other items of smaller magnitude.

At Carville, for instance, to show you the distribution, that $11.14 is made up of $9.02 in salaries, 78 cents in supplies, $1.31 in subsistence, and 3 cents in other categories.

Mr. FERNANDEZ. No capital expenditures of any sort go into it?

Mr. HUNT. No, sir.

ACREAGE AT FORT STANTON

Mr. FERNANDEZ. With respect to Fort Stanton, the total number of acres in that reservation is 26,374.

Dr. HUNT. Thank you.

Mr. FERNANDEZ. Of that you have 1,395 set aside for the dairy herd, as I understand it. Do you happen to know whether that is fenced in? I believe it is.

Dr. HUNT. Yes; the reservation as a whole is fenced, and there are several pastures each enclosed by a fence.

Mr. FERNANDEZ. Out of that, approximately 23,000 acres are used mainly for grazing purposes for livestock, other than the dairy?

Dr. HUNT. Yes, sir.

PREVIOUS CONSIDERATIONS OF TRANSFERRING GRAZING LAND

Mr. FERNANDEZ. I called this matter to your attention back in early 1951, and at that time I felt very strongly that you agreed with us that it should be better utilized by leasing through the appropriate agencies of the Government to private industry. What steps have been taken toward bringing that about, if any?

Dr. HUNT. So far as I know, there have been no specific steps taken other than the continued discussion within our own organization of the advisability of getting out of the beef operation. We have had some contact with the Public Buildings Service on an informal basis. So far as I know no formal representation has been made to them.

It is my understanding that there may be some problem in doing what you suggest under the present law, but we could certainly continue to explore it.

Mr. FERNANDEZ. There is no impediment so far as I can find, because at that time we went to the extent of obtaining approval of the Bureau of Land Management to take it over and administer it in the same manner that they are administering other public lands in the Federal service without withdrawing the land from the United States Public Health Service. Second, that land was assigned to the Fort Stanton Hospital by Executive order of April 1, 1899, and another order of November 1, 1899, and that being true, a reassignment, when you are ready for it, can be made by Executive order.

Now, can we have assurance—the reason I ask that is because if we do have that assurance then I would like to go into the operations of it, so that the cost of the ranching operations may be segregated and deleted for 1954—that such a transfer can be made by the end of this fiscal year?

Dr. HUNT. I am not sure I am in a position to give you that assurance in the form that you wish, Mr. Fernandez. There are many factors which enter into the situation.

Mr. FERNANDEZ. I will ask it this way: Is your Service convinced that you should not be operating this large tract of land for beef-raising exclusive of the dairy operation?

Dr. HUNT. Well, you raise one interesting problem there. If we got rid of the beef operation and maintained the dairy operation it might make the dairy operation inordinately expensive, because the same sort of people are now doing both. I do not know. We have not investigated that possibility in sufficient detail so that I can give you good figures, but I raise that at least a possible consequence of a split operation of that sort.

Mr. FERNANDEZ. Well, we have raised the question since early 1951, and it was raised once before, in 1940.

Dr. HUNT. It has been, as I say, under consideration. I must say that there has never been a clear-cut determination within the Service as to the value or lack of value of that operation. In other words, there has been some difference of opinion as to whether the hospital should or should not continue to operate that function. Part of the problem was pointed up during the war when, with meat shortages all over the country, it was particularly helpful for the hospital to have its own source of meat right on its own grounds.

Mr. FERNANDEZ. I agree with you that at one time that was advantageous, but now you have very good transportation to Capitan and Fort Stanton, and you can get your beef without any trouble. I just do not see why it is necessary for Fort Stanton to operate it at all.

Dr. HUNT. That certainly is a point of view that has been held by a number of people within the service. I think it is fair to say that the contrary view has also been held by some of our people. They felt that it was an activity worth continuing, particularly in view of the wartime experiences with shortages.

I can certainly give you assurance that we will look at it very closely again.

Mr. FERNANDEZ. We have contacted the Bureau of Land Management, which would be the agency which would operate it, presumably.

We have contacted the General Services Administration. They all say that the decision is up to the Public Health Service. Is it within the Public Health Service that you are having differences of opinion?

Dr. HUNT. We have had; yes, sir.

Dr. SCHEELE. Mr. Chairman, we will look into that. I assure you we will do the thing that is right to do. I do not know the background of this, but we will take an early look at the problem of running a dairy and, in addition, the problem of the large acreage of land. Those are two problems, as I see them.

Mr. STEPHENS. Mr. Fernandez, there is one thing I would like to inject, having helped process these budgets for a number of years now. It seems to me there are extenuating circumstances which might have delayed the decision on the farm, and that has been the very nebulous feeling that Fort Stanton itself might be abandoned as a hospital. I know that the fellows would be reluctant to make a policy decision on the herd when, within 60 or 90 days or 10 months, they might have to make a decision with reference to the continued operation of the hospital itself. That has been in the thinking now for more than a year, I know.

Mr. FERNANDEZ. I fully appreciate that. That is one of the reasons why I was inquiring how you go about it. The hospital building and facilities would not necessarily be treated together with the rest of the purely grazing land at the time they are declared surplus. They are sort of separate and apart, in my opinion.

Well, I will not go into the operations of it at the present time if we can have that assurance that you will look into it between now and the next few weeks, so that it can be done by the end of this fiscal year if it is going to be done at all.

Dr. SCHEELE. Yes, sir.

Mr. FERNANDEZ. As I pointed out, it is a very simple matter, if the Public Health Service feels that it does not have to be in the cattle business. I do not think they should be. Thank you, Mr. Chairman. That is all.

Mr. BUSBEY. Are there any further questions? If not, the committee will stand adjourned until 2 o'clock.

THURSDAY, FEBRUARY 26, 1953.

FOREIGN QUARANTINE SERVICE

WITNESSES

DR. CALVIN B. SPENCER, CHIEF, DIVISION OF FOREIGN QUARANTINE
DR. RALPH GREGG, ASSISTANT CHIEF, DIVISION OF FOREIGN QUARANTINE
ELSIE FEIST, BUREAU OF MEDICAL SERVICES
DR. JACK MASUR, CHIEF, BUREAU OF MEDICAL SERVICES
DR. G. HALSEY HUNT, ASSISTANT SURGEON GENERAL, ASSOCIATE CHIEF, BUREAU OF MEDICAL SERVICES

SALARIES AND EXPENSES

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$3,048,200	$3,065,000	$3,100,000
Reimbursements from non-Federal sources	2,193		
Total available for obligation	3,050,393	3,065,000	3,100,000
Unobligated balance, estimated savings	−15,558		
Obligations incurred	3,034,835	3,065,000	3,100,000

NOTE.—Reimbursements from non-Federal sources above are from the proceeds of sale of personal property (40 U. S. C. 481 (c)).

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
1. Medical examination of aliens and quarantine inspection of persons, vessels, and aircraft entering United States ports	$2,553,834	$2,556,000	$2,556,000
2. Medical examination of visa applicants in foreign countries	318,312	337,000	372,000
3. Administration	162,689	172,000	172,000
Obligations incurred	3,034,835	3,065,000	3,100,000

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Total number of permanent positions	603	603	603
Full-time equivalent of all other positions	30	31	31
Average number of all employees	579	575	580
Average salaries and grades:			
General schedule grades:			
Average salary	$4,404	$4,464	$4,464
Average grade	GS-6.4	GS-6.4	GS-6.4
Crafts, protective, and custodial grades:			
Average salary	$3,596	$3,583	$3,582
Average grade	CPC-5.8	CPC-5.7	CPC-5.7
Ungraded positions: Average salary	$2,894	$2,352	$2,352
01 Personal services:			
Permanent positions	$2,437,850	$2,465,277	$2,493,277
Part-time and temporary positions	152,189	157,500	157,500
Regular pay in excess of 52-week base	8,917	9,078	9,078
Payment above basic rates	130,812	134,445	136,445
Total personal services	2,729,768	2,766,300	2,796,300
02 Travel	52,646	52,000	55,600
03 Transportation of things	34,642	26,700	26,900
04 Communication services	17,731	17,800	17,800
05 Rents and utility services	42,878	43,400	43,400
06 Printing and reproduction	4,675	3,900	3,900
07 Other contractual services	43,479	40,800	40,800
08 Supplies and materials	100,627	105,300	106,500
09 Equipment	42,469	40,700	40,700
13 Refunds, awards, and indemnities	60	----------	----------
15 Taxes and assessments	1,860	2,100	2,100
Subtotal	3,070,835	3,099,000	3,134,000
Deduct charges for quarters and subsistence	36,000	34,000	34,000
Obligations incurred	3,034,835	3,065,000	3,100,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$404,823	$274,126	$361,126
Obligations incurred during the year	3,034,835	3,065,000	3,100,000
	3,439,658	3,339,126	3,461,126
Deduct:			
Reimbursable obligations	2,193	----------	----------
Adjustment in obligations of prior years	168,669	----------	----------
Unliquidated obligations, end of year	274,126	361,126	431,126
Obligated balance carried to certified claims account	6,023	----------	----------
Total expenditures	2,988,647	2,978,000	3,030,000
Expenditures are distributed as follows:			
Out of current authorizations	2,758,516	2,790,000	2,820,000
Out of prior authorizations	230,131	188,000	210,000

Mr. BUSBEY. The committee will come to order.

We have before us the appropriation request for fiscal year 1954 for the Foreign Quarantine Service.

Dr. Spencer, we are very happy to welcome you back to the committee.

Dr. SPENCER. Thank you, sir.

Mr. BUSBEY. Would you like to submit your prepared statement for the record and summarize it for the committee, please.

Dr. SPENCER. Thank you, sir. I will submit the statement and summarize it. I believe I can make it more brief.

(The statement follows:)

Mr. Chairman and members of the committee, the appropriation estimate of $3,100,000 to cover the operation of the Division of Foreign Quarantine for the fiscal year 1954 is presented as the minimum required to afford a reasonable protection of the people of the United States from the importation of disease from other countries. The Division maintains this protection by discharging two functions provided for by separate legal authorizations. The first function is the foreign quarantine work, which is carried out to keep the epidemic diseases from being introduced into the United States by travel and commerce from foreign countries. The second function, the medical examination of aliens, is carried out to keep immigrants and alien visitors from adding to our country's present burden of mentally or physically defective persons and to our problems with the communicable diseases. Both are old established governmental functions.

Foreign quarantine has been recognized as a Federal responsibility since 1878. Prior to that time quarantine was carried out primarily as a State or local function against ships arriving from foreign countries in times of outbreaks of yellow fever, cholera, and other epidemic diseases. Local control of quarantine resulted in a lack of uniformity and effectiveness. By acts of 1878 and 1893 Congress recognized the need for a national quarantine system and authorized the Federal Government to prescribe and enforce quarantine regulations and to take over the local quarantine stations. Authority for the foreign quarantine work is now contained in sections 361 to 369 of the Public Health Service Act (Public Law 410, 78th Cong.).

The foreign quarantine work is a specialized program of preventive medicine with the primary purpose of preventing the introduction into the United States, its Territories, and possessions of "quarantinable diseases" as defined in the Foreign Quarantine Regulations of the Public Health Service and the International Sanitary Regulations of the World Health Organization. These diseases are smallpox, yellow fever, typhus fever, cholera, plague, and relapsing fever. Attention is also given to other communicable diseases, particularly certain diseases of animals that can be transmitted to persons.

Protective quarantine measures fall into three categories:

1. Inspection and treatment of persons, and certain imports, including lather brushes; dogs, cats, and monkeys; parrots and other psittacine birds; laboratory cultures or other infected materials.

2. Rodent control on ships, piers, airplanes, airports, and in surrounding communities.

3. Insect control in airplanes and on airports, in nearby communities, and on ships and piers.

The application of these measures is based on our knowledge of the prevalence of the quarantinable diseases in various parts of the world. The World Health Organization gives daily notification by radio of distribution and prevalence of epidemic, communicable diseases, which, together with a weekly report, gives accurate information on which to base quarantine action.

Epidemiological notifications show the constant existence of smallpox in Asia, Africa, and South America, with occasional sharp outbreaks in many countries. Plague continues to be prevalent in Asia, Africa and Madagascar, and South America. *Typhus fever* is present in all major countries except United States and Canada. *Cholera* remains entrenched in southeast Asia. *Yellow fever*, endemic in the jungles of South America and Panama, continues to progress northward into Central America; equatorial Africa is also infected. *Relapsing fever* may be encountered in South America, Africa, and Asia.

During the past 3 years in the conduct of the foreign quarantine operation the traffic by vessels and aircraft has progressively increased, while the average employment of quarantine personnel for the fiscal years 1950, 1951, and 1952 has been 665, 619, and 579, respectively. This decrease has been made possible by the continued development of more efficient procedures, application of more effective materials, and improved training of specialized personnel.

The medical examination of aliens is carried out at United States consulates abroad and at ports in this country. Medical officers are stationed at several of the major consulates to examine visa applicants as part of the determination of their eligibility to migrate to the United States. In cooperation with the Immigration and Naturalization Service, quarantine personnel also examine aliens at ports of entry, to determine their admissibility.

The Immigration Act of 1891 assigned to officers of the Marine Hospital Service the responsibility of performing the medical examination of aliens at ports of entry. This was the first organized effort on the part of the Federal Government to effect measures intended to safeguard our population from the intrusion of mentally disordered or deficient persons or persons who might become public charges from physical causes, or to exclude those suffering from loathsome or dangerus contagious diseases not covered by national quarantine laws and regulations. This authority has been carried forward by subsequent legislation.

The Immigration Act of 1917 authorized the assignment of Public Health Service officers at United States consulates to examine aliens. This screening of visa applicants abroad, which was started in 1925, was helpful in avoiding hardship to rejected immigrants and their families, and was also advantgeous to the United States by diminishing the problem of deporting inadmissible persons.

During World War II this medical examination work was discontinued at all points in Europe except London. After the war, as the issuance of immigration visas was resumed, medical officers were reassigned to the major consulates, and the supervisory office in Paris was reestablished.

This appropriation will provide personnel to cover all ports of entry into the United States and its insular possessions and for the medical examination of visa applicants at a limited number of consular posts in foreign countries. There are altogether 287 stations or posts covered, of which 233 are in the United States, 27 in insular possessions, and 27 in foreign countries. The current estimate will provide for an average employment of all personnel of 580, which includes full-time employment of 549 and contract or other part-time employment equivalent to 31 full-time positions.

At best we can afford only a thin line of personnel along the border and shorelines to protect the United States against the potential hazards of disease that may be incident to the entry of every person, airplane, or vessel engaged in international travel.

The success of the program of the medical examination of aliens does not readily lend itself to monetary expression, but the implantation of one mentally-defective person into our society may be reflected in the economic and social status of his progeny for a century to come. The majority of aliens refused admission because of health conditions are either mental or tuberculosis cases. If allowed to enter the country, it is likely that most of them would eventually become institutionalized at public expense. The average total cost to our economy per case has been estimated as high as $40,000. When we consider that 613 cases of tuberculosis and mental disease were discovered and rejected at American consulates by Public Health Service medical examiners in 1952, and that 518 were detected at United States ports and excluded or admitted under bond, we see that this program actually saves our national economy many millions of dollars annually.

The protection afforded by the foreign-quarantine function under this appropriation is readily recognized. Every person in this country derives a definite benefit from the program. The rigid inspection and vaccination program has been a large factor in reducing the number of smallpox cases in the United States during the past 25 years from 33,750 cases reported in 1927 to a low incidence of 19 cases in 1952. For 25 years annual morbidity reports have shown no cases of yellow fever in the United States. No case of cholera has occurred in our country since 1911.

While rodent plague is endemic in many of our Western States, our quarantine barriers have been effective in preventing the introduction of plague into any of our ports from abroad during the past 29 years.

The effective service provided under this appropriation—both the foreign quarantine work including inspection and vaccination of incoming persons, and the medical examination of aliens—costs the people of the United States less than 2 cents per person annually.

The gradual upward trend of the volume of work performed under this appropriation, indicated for the fiscal years 1951 anad 1952, is being borne out by an analysis of the estimated trend through the fiscal year 1953 based on the actual workload from July through December 1952.

By comparison of the estimated figures for 1953 with the actual figures for 1952, the major items indicate a significant upward trend as follows:

Aircraft arrivals from 45,638 to 46,978
Persons inspected for quarantine, 35,932,115 to 40,204,598
Medical examination of aliens at ports of entry, 1,633,706 to 1,638,502

Medical examination of visa applicants abroad, 112,928 to 120,394
Vaccinations, 237,880 to 274,212

Since the activities have been showing an appreciable increase from year to year, we have every reason to expect a continuing workload increase in 1954. We are reasonably sure that this increase can be absorbed inasmuch as it will occur at stations already staffed, rather than in new areas.

This estimate carries an item of $35,000 increase in the foreign phase of our program, which will provide five additional medical officers. These officers will be detailed to consulates for the medical examination of visa applicants where the workload warrants, but cannot be provided for from the 1953 funds. These proposed coverages include Liverpool, Dublin, Glasgow, and Hong Kong. The heavy workload at Munich will require an additional medical officer, who can supervise the operations at Salzburg and Vienna, as well.

The estimate submitted for the fiscal year 1954 represents the minimum necessary to maintain our present border and coastline inspectional services as a protection against the introduction of disease from abroad and at the same time provide for the medical examination of aliens at United States ports of entry and at American consulates in foreign countries.

GENERAL STATEMENT

Dr. SPENCER. The appropriation in the amount of $3,100,000 is for the operation of the Foreign Quarantine Division, Public Health Service, for the fiscal year 1954.

The objective of the Division in its operation is to protect the people of the United States against the introduction of epidemic or contagious disease.

The work of the Division is divided into two principal functions, each of long-standing legal authorization.

NATIONAL QUARANTINE

The first function, that of the national quarantine, is authorized at present by Public Law 410, section 361 to 369. This is a program of specialized preventive medicine for epidemic control for the purpose of preventing introduction of quarantinable diseases, defined as such by the International Sanitary Regulations and by the United States Quarantine Regulations. Those diseases are smallpox, yellow fever, typhus fever, cholera, plague, and by the terms of the new International Sanitary Regulations which became effective October 1, 1952, relapsing fever has been added.

The quarantine is accomplished through the inspection or treatment of persons, certain imports, including lather brushes, certain animals, dogs, cats, monkeys, birds, specifically psittacine, parrots, and others of the family, and laboratory cultures, or other infected materials—viruses and bacteria and the like.

By rodent control carried out on ships, piers, on aircraft, on and around airports and through cooperation with local communities, that is, the organized health departments of the local communities. This program is carried out in the surrounding community of ports and airports.

By insect control, which, as in rodent control, affects coveyances. This primarily is on aircraft, on and around airports, and, in cooperation with local authorities out into the surrounding communities; secondarily, on ships, around piers, or in the communities surrounding the port areas.

INCIDENCE OF QUARANTINABLE DISEASES IN WORLD

In determining the necessity for quarantine inspection of traffic, we rely on epidemiological information gathered from a number of sources. One main source is from World Health Organization. The WHO maintains a daily radio broadcast of epidemiological information, in addition to which they publish a weekly bulletin.

Epidemiological notifications indicate that smallpox is widely prevalent throughout the world and is to be found largely in Asia, Africa, South America, with sharp outbreaks in many other countries, depending upon being carried by traffic.

Plague is prevalent in Asia, Africa, Madagascar, and South America.

Typhus fever is present and affects most of the major countries, the exception being the United States and Canada.

Cholera is to be found principally in Southeast Asia.

Yellow fever is endemic in the jungles in South America. Recently it has progressed through the Republic of Panama into Central America. It is also to be found in Equatorial Africa.

Relapsing fever has distribution in South America, Africa, and Asia.

We note by experience in the last several years that travel internationally is increasing, both by air and by surface vessels, also across our international borders on this continent.

AVERAGE EMPLOYMENT RELATED TO WORKLOAD

In spite of this increase, the average employment of quarantine personnel has decreased.

I might cite from the prepared statement certain evidences of increase in the form of figures, if you wish, or we could leave it as a matter of record in the statement.

Mr. BUSBEY. It would be well for you to insert that statement in your summary.

(The matter referred to is as follows:)

5-year work trend of important factors

	1950	1951	1952	1953 estimate [1]	1954 estimate [1]
Quarantine inspection:					
Vessels inspected	22,389	25,343	29,728	34,113	38,498
Persons on vessels inspected	1,518,345	1,509,045	1,875,531	2,242,017	2,608,503
Airplanes inspected	39,921	43,036	45,638	48,240	50,842
Persons on airplanes inspected	517,276	616,515	703,175	789,835	876,495
Mexican-border inspections	28,037,060	29,569,836	33,353,409	37,136,982	40,920,555
Persons treated	218,616	315,912	432,719	549,526	666,333
Immigration medical examination:					
Examination of aliens (United States ports and airports)	[2] 1,330,622	[2] 1,428,639	[2] 1,633,706	1,695,022	1,875,904
Medical certifications	[2] 53,135	[2] 50,622	[2] 50,257	25,908	25,919
Visa applicants examined (abroad)	89,229	81,206	112,928	144,650	176,372
Visa applicant medical notifications (abroad)	26,235	23,664	33,739	43,814	53,889
Personnel:					
Budgeted positions	650	623	603	603	603
Average employment	665	619	579	575	580

[1] Estimated on the basis of the increased workload in 1952 over 1951.
[2] Contain displaced persons arriving at United States ports and airports of entry.

Dr. SPENCER. This is just a brief statement of experience. Very well, I will go on from there.

MEDICAL EXAMINATION OF ALIENS

The second function of the quarantine service is the examination of aliens at United States consulates abroad and at ports in this country. The present authority is the immigration and naturalization law of 1952.

Historically, the first law placing responsibility on Public Health Service for the examination of aliens at United States ports of entry was in 1891. Later, in 1917 the law restated that authorization and added the authorization to detail Public Health Service officers abroad at consulates.

The act of 1924 restated again, broadened somewhat, but continued the authorization to detail officers abroad for the purpose of advising the consular officers as to the medical condition of these applicants.

The object of this program is to prevent the intrusion of mentally disordered or deficient persons into the population; also to prevent the introduction of those afflicted with tuberculosis, or persons who, because of severe physical defects, might become public charges.

Also, the intent was to exclude those aliens who were suffering from loathsome or dangerous contagious diseases.

Broadly, this is being accomplished, as was indicated in the historical authorization, by the medical examination of these applicants at consulates abroad, with notification to the consuls providing for exclusion, or, let's say, a refusal of visa which would permit their immigration.

It is also accomplished through the medical examination of aliens at United States ports of entry, the ports and airports, in which we advise the Immigration and Naturalization Service as to the medical condition of the person, whether they are suitable for admission, which, coupled with their operation within their regulations, assists in the determination of admissibility.

These two functions, that of quarantine and medical examination of aliens, are carried on at 287 stations or points of coverage throughout the world. Those are broken down, roughly, 233 in the United States at seaports, airports, and border-crossing points; 27 in insular possessions; and 27 in foreign countries.

STATUS OF PROGRAM

The appropriation, as noted from the material given in the tabulation, asks for 603 positions. It will be noted that we have stated in our statement that the average employment that this appropriation will stand is 580, which includes 31 full-time position equivalents of contract and other part-time personnel.

We realize it is difficult to appraise fully from a monetary standpoint the effectiveness of a program of medical examination of aliens. However, it is important to realize that the introduction of a mentally defective case affects progeny for generations to come.

We would call attention to the fact that the majority of exclusions of aliens are for tuberculosis or mental conditions. We would add too, that there are a number of serious physical defects which might

affect their status of work; also a lesser number of loathsome or dangerous contagious conditions.

If an alien who migrated to this country were hospitalized, that is, if unrecognized he were able to obtain admissibility to the country and came into a community and was hospitalized, usually it is for a long time because through the process of detention, treatments bring them to the point of being able to be deported, the investigation by board of special inquiry and then deportation, are matters which take time and are expensive. These are variously estimated up to approximately $40,000 per individual.

So it might be recognized that since in 1952 there were 613 rejections abroad of visa applicants for mental conditions and tuberculosis, and also that we detected at United States ports of entry on arrival 518 with mental conditions or tuberculosis, considerable monetary return has been realized on the money spent in this appropriation.

The quarantine program might be appraised somewhat easier when we consider that this benefits broadly everyone without respect to community, and that the inspection and vaccination procedures during the past years have reduced the prevalence of smallpox from that in 1927, a level of 33,750 reported cases to 19 reported cases in 1952. During the same 25-year span there have been no cases of yellow fever in the United States.

There have been no cases of cholera reported in the United States since 1911. While plague is endemic in many of our Western States, there has been no introduction of the plague at ports or airports of the country in the last 29 years.

This then reflects again the considerable importance of our preventive program.

This estimate submitted for the fiscal year 1954 represents the minimum necessary to maintain our present border and coastline inspection services as a protection against the introduction of disease from abroad and at the same time provide for the medical examination of aliens at United States ports of entry and at American consulates in foreign countries.

Mr. BUSBEY. Thank you Dr. Spencer. I was in Europe in 1951 for 14 weeks, and I had occasion at that time to check up on your service. I was very favorably impressed with the work your quarantine service is doing over there.

Dr. SPENCER. I am pleased to know you were able to visit those places.

Mr. BUSBEY. The people there said that it was a rarity for a Member of Congress to show up at some of the places. In fact, I had been the only Member of Congress who had ever shown up at some of them.

Dr. SPENCER. We welcome you, sir.

FUNDS REQUESTED OF BUDGET BUREAU

Mr. BUSBEY. What did you request of the Bureau of the Budget, Dr. Spencer?

Dr. SPENCER. I have that figure right here, sir. That was $3,444,000.

Mr. BUSBEY. And they allowed you $3,100,000, which is $35,000 over the 1953 appropriation?

Dr. SPENCER. That is correct, sir.

FACILITIES AT MARCUS HOOK

Mr. BUSBEY. I wonder if you wish to comment on the situation that exists at Marcus Hook. I understand that negotiations with Sun Oil Co. have been going on for some time in an attempt to work out a property transfer which would be mutually beneficial to both the company and the Federal Government?

Dr. SPENCER. That is correct. For some time the Sun Oil Co. has been desirous of obtaining that property which we occupy and which was obtained from the State of Pennsylvania. I believe the total land space is about 19 acres, part of which is improved. There are old buildings on the station.

Mr. BUSBEY. How old are those buildings?

Dr. SPENCER. I am afraid I cannot answer that.

Mr. BUSBEY. Could you make a rough estimate?

Dr. SPENCER. Just prior to the turn of the century, I think. It was operated as a quarantine station by the State of Pennsylvania until we took it over. We operated it as a permissive occupancy for some number of years, and it was finally turned over as deed property.

This property is larger than our needs. We could improve our situation by an exchange. Negotiations are being made by Public Buildings Service, General Services Administration, attempting to obtain proper facilities on offered property; that is, property offered by Sun Oil Co. in exchange.

We have drafted the type of building we consider to be adequate and more satisfactory to our needs. That property is upriver just beyond the Sun Oil property, adjacent to the quarantine anchorage.

Mr. BUSBEY. Is there a possibility that agreement might be reached soon?

Dr. SPENCER. That, I think, is a possibility, depending upon the negotiations with Public Buildings Service.

FEASIBILITY OF RENTING BOARDING LAUNCHES

Mr. BUSBEY. The launch at Philadelphia or Marcus Hook is rented, is it not?

Dr. SPENCER. That is correct.

Mr. BUSBEY. And you found that more economical than maintaining a boat and a crew.

Dr. SPENCER. To a certain degree. I might qualify. On the surface at the present time it is more economical. It is a single unit, and apparently it reflects a saving. However, if the traffic increases to the point of needing an additional boat, and additional services, it is possible that this economy will not be reflected.

Mr. BUSBEY. Then, with the additional traffic, is it true that at New York and other stations, like New Orleans, there would be no economy in renting a boat?

Dr. SPENCER. New Orleans and New York are different to a certain extent. The traffic at New York is of larger vessels in open bay

water, necessitating a larger launch for boarding; that is for safety of the boarding party.

There is a great deal more traffic in New York than there is in Marcus Hook, which necessitates the use of additional vessels.

New Orleans, if I may go to that one immediately, has the different situation in time of boarding. Here is an exception in that tankers en route to Baton Rouge must necessarily be taken care of expeditiously so that they can go on up. This necessitates the use of a launch somewhat beyond the hours regularly stated, 12 hours; they board up to 16 hours there.

WORK WITH MEXICAN FARM-LABOR PROGRAM AND WETBACKS

Mr. BUSBEY. How are you able to cope with the situation at the Mexican border respecting the laborers that come across from Mexico? You are not able to make any inspection of those people, are you?

Dr. SPENCER. Those regularly contracted for are inspected by personnel which we maintain at five points. If you are referring to the wetbacks, we do not have control over those people. We do not have police powers for their apprehension. Those that are apprehended are brought back to the border by Immigration, and then they are deported without our having seen them.

Mr. BUSBEY. Do the wetbacks, in your estimation, present a medical hazard to our country?

Dr. SPENCER. Definitely. It is one I am afraid we cannot claim to have under control at the moment. We do get them in the communities, however—in the local-community public-health services—and deal with certain of the problems that may be presented.

Mr. FERNANDEZ. The wetbacks would not be admissible whether they were healthy or unhealthy; they just admit themselves without anybody giving them permission to come in. That is the situation.

Dr. SPENCER. That is correct.

Mr. FERNANDEZ. What is needed is more funds to enforce the immigration laws.

Dr. SPENCER. That is right.

Mr. BUSBEY. Thank you very much, Doctor. We are always happy to see you before our committee.

Dr. SPENCER. It is a privilege. Thank you.

MONDAY, MARCH 30, 1953.

NATIONAL INSTITUTE OF HEALTH, OPERATING EXPENSES

WITNESSES

DR. WILLIAM H. SEBRELL, DIRECTOR, NATIONAL INSTITUTES OF HEALTH
DR. JAMES A. SHANNON, ASSOCIATE DIRECTOR, NATIONAL INSTITUTES OF HEALTH
DR. C. J. VAN SLYKE, ASSOCIATE DIRECTOR, NATIONAL INSTITUTES OF HEALTH
ROBERT E. LEARMOUTH, FINANCIAL MANAGEMENT OFFICER, NATIONAL INSTITUTES OF HEALTH
ALBERT SIEPERT, EXECUTIVE OFFICER, NATIONAL INSTITUTES OF HEALTH

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$15,756,500	$16,598,750	$5,180,000
Reimbursements from non-Federal sources	1,629	70,000	265,000
Reimbursements from other accounts	2,417,263	3,351,400	7,912,300
Total available for obligation	18,175,392	20,021,150	13,357,300
Unobligated balance, estimated savings	−39,758		
Obligations incurred	18,135,634	20,020,150	13,357,300
Comparative transfer from "Commissioned officers, pay, and so forth, Public Health Service"	9,467		
Comparative transfer to—			
"Arthritis and metabolic disease activities, Public Health Service"	−4,064,450	−4,626,700	
"Microbiology activities, Public Health Service"	−5,502,127	−5,650,200	
"Neurology and blindness activities, Public Health Service"	−1,230,969	−1,537,300	
"Salaries and expenses, Office of the General Counsel, Office of the Administrator, Federal Security Agency"		−3,000	
Comparative reimbursable obligations transferred from other accounts	1,327,385	2,029,600	
Total obligations	8,674,940	10,232,550	13,357,300

NOTE.—Reimbursements from non-Federal sources above are from the proceeds of sale of personal property (40 U. S. C. 481 (c)) for 1952. For 1953 and 1954, the amounts reflect proceeds from sale of meals.

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
Direct Obligations			
Appropriated funds:			
1. Grants for research and training:			
(*a*) Research projects	$4,304,587	$4,255,000	$4,500,000
(*b*) Research fellowships	393,428	199,000	124,000
2. Direct operations:			
(*a*) Research	139,863		
(*b*) Other direct operations: (1) Review and approval of research and training grants	560,572	556,350	556,000
Total appropriated funds	5,398,450	5,010,350	5,180,000
Reimbursements from non-Federal sources:			
2. Direct operations:			
(*a*) Research	1,629	70,000	265,000
Total direct obligations	5,400,079	5,080,350	5,445,000
Obligations Payable Out of Reimbursements From Other Accounts			
2. Direct operations:			
(*a*) Research	2,666,884	4,451,200	7,144,500
(*b*) Other direct operations:			
(1) Review and approval of research and training grants	9,993		
(2) Administration	597,984	701,000	767,800
Total obligations payable out of reimbursements from other accounts	3,274,861	5,152,200	7,912,300
Total obligations	8,674,940	10,232,550	13,357,300

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Summary of Personal Services			
Total number of permanent positions	777	1,740	2,174
Full-time equivalent of all other positions	11	12	15
Average number of all employees	727	1,078	1,848
Average salaries and grades:			
General schedule grades:			
Average salary	$4,322	$4,187	$4,116
Average grade	GS–6.0	GS–5.9	GS–5.9
Crafts, protective, and custodial grades:			
Average salary	$3,041	$2,956	$2,921
Average grade	CPC–4.2	CPC–4.3	CPC–4.2
Ungraded positions: Average salary	$3,245	$3,285	$3,285
Personal service obligations:			
Permanent positions	$2,775,869	$4,128,667	$6,561,218
Part-time and temporary positions	36,516	42,800	75,300
Regular pay in excess of 52-week base	11,038	23,929	30,536
Payment above basic rates	60,095	87,600	113,250
Total personal service obligations	2,883,518	4,282,996	6,780,304
Direct Obligations			
Appropriated funds:			
01 Personal services	559,570	463,850	463,500
02 Travel	51,562	48,000	48,000
03 Transportation of things	276	200	200
04 Communication services	7,057	6,000	6,000
05 Rents and utility services	1,193	1,000	1,000
06 Printing and reproduction	11,334	10,000	10,000
07 Other contractual services	12,496	5,000	500
08 Supplies and materials	24,100	20,000	20,000
09 Equipment	33,254	1,200	5,700
11 Grants, subsidies, and contributions	4,698,015	4,454,000	4,624,000
13 Refunds, awards, and indemnities	55		
15 Taxes and assessments	1,010	1,100	1,100
Subtotal	5,399,922	5,010,350	5,180,000
Deduct charges for quarters and subsistence	1,472		
Total obligations payable out of appropriated funds	5,398,450	5,010,350	5,180,000

Obligations by objects—Continued

Object classification	1952 actual	1953 estimate	1954 estimate
Reimbursements from non-Federal sources:			
01 Personal services		$24,000	$90,000
08 Supplies and materials		46,000	175,000
09 Equipment	$1,629		
Total obligations payable out of reimbursements from non-Federal sources	1,629	70,000	265,000
Total direct obligations	5,400,079	5,080,350	5,445,000
Obligations Payable Out of Reimbursements From Other Accounts			
01 Personal services	2,323,948	3,795,146	6,226,804
02 Travel	9,900	35,300	55,800
03 Transportation of things	1,694	8,100	14,300
04 Communication services	33,222	70,800	82,100
05 Rents and utility services	129,689	178,300	304,800
06 Printing and reproduction	27,994	36,300	36,300
07 Other contractual services	105,768	73,400	60,800
08 Supplies and materials	470,511	811,400	1,129,400
09 Equipment	166,915	138,300	74,300
10 Lands and structures	1,293		
13 Refunds, awards, and indemnities	2,790		
15 Taxes and assessments	5,685	12,100	18,600
Subtotal	3,279,409	5,159,146	8,003,204
Deduct charges for quarters and subsistence	4,548	6,946	90,904
Total obligations payable out of reimbursements from other accounts	3,274,861	5,152,200	7,912,300
Total obligations	8,674,940	10,232,550	13,357,300

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$2,479,735	$3,204,205	$3,600,000
Obligations incurred during the year	18,135,634	20,020,150	13,357,300
	20,615,369	23,224,355	16,957,300
Deduct:			
Reimbursements received	2,418,892	3,421,400	8,177,300
Adjustment in obligations of prior years	93,224		
Unliquidated obligations, end of year	3,204,205	3,600,000	2,663,000
Obligated balance carried to certified claims account	3,724		
Total expenditures	14,895,324	16,202,955	6,117,000
Expenditures are distributed as follows:			
Out of current authorizations	13,359,026	14,222,955	3,885,000
Out of prior authorizations	1,536,298	1,980,000	2,232,000

Mr. BUSBEY. The committee will come to order.

We have before us for consideration the appropriation request for fiscal year 1954 for the operating expenses of the National Institutes of Health. Dr. Sebrell, we welcome you back to the committee. We would be very happy at this time to hear your general statement.

Dr. SEBRELL. Thank you, Mr. Chairman. I have a statement I have prepared here which I would like to present to you and the committee.

GENERAL STATEMENT

Mr. Chairman and members of the committee, I am very happy for this opportunity to present a few highlights of our research program at the National Institutes of Health.

First let me say that at NIH we are a group of medical research scientists. We take great pride in the high professional standing of

our staffs, and this pride is borne out both by the quality and volume of their scientific findings and by the national and international recognition that has been bestowed upon them.

The work of the National Institutes of Health today reflects the progress that has been made in medicine and public health during the 66 years that the Public Health Service has conducted research. The emphasis and direction of our research has changed in response to shifts in the importance of various causes of illness, death, and disability. But its purpose has always been the same—through research to conquer the diseases of the greatest danger to the American people.

The Nation's critical health problems formerly were the epidemic diseases. A few of these, such as influenza and poliomyelitis, remain unsolved. But most of them have been brought under control in this country by the application, through sound medical and public health practice, of laboratory, clinical, and epidemiological research. As a result, Americans today live longer. Our major health problems now are heart disease, cancer, mental illness, the metabolic and neurological disorders—in short, diseases which are largely associated with aging and disturbed body functions, rather than with the invasion of the body by foreign organisms.

The Congress recognized the need for this change in emphasis in our research by the establishment in 1937 of the National Cancer Institute. This Institute also added new research functions, such as support of medical research through grants, research fellowships, and assistance to medical schools and universities in the construction of research facilities.

World War II provided a conclusive demonstration that fundamental research pays off—not only in nuclear energy and electronics, but in the medical and biological sciences as well. Since that war Congress has given further Federal recognition to public and professional interest in medical research by authorizing several new programs at the National Institutes of Health. To the National Cancer Institute, Congress has authorized the addition of the National Heart Institute, the National Institute of Mental Health, the National Institute of Dental Research, the National Microbiological Institute, and most recently—in 1951—the National Institute of Arthritis and Metabolic Diseases, and the National Institute of Neurological Diseases and Blindness.

LABORATORY INVESTIGATIONS

Some of the greatest discoveries in medicine have come from the scientists in the laboratories of these institutes, and they are continuing every day to make important discoveries as they seek a cure for cancer, better treatment for heart disease, the cause of neurological diseases, a means to prevent poliomyelitis, better treatments for arthritis, and similar projects.

Let me cite several examples of recent progress. A scientist in the Arthritis Institute a few weeks ago announced the successful isolation of an important B vitamin. Scientists in the Heart Institute recently found a complex system of proteins which apparently control deposits of fat on the arterial walls, causing atherosclerosis—the most common form of hardening of the arteries. Scientists in the Cancer Institute

have just reported a method for protecting experimental animals against radiation injury. Scientists in two institutes have reported promising results from the use of Daraprim in combination with a folic acid antagonist to inhibit the disease, leukemia, or cancer of the blood. Daraprim, in turn, has been found by other NIH scientists to be an effective antimalarial drug.

CLINICAL RESEARCH

These are laboratory studies. But with the increased emphasis on research against the chronic diseases, it became evident that there was—at the National Institutes of Health, as elsewhere in the medical research world—an urgent need for the integration of laboratory with clinical research facilities. In order to achieve the best results, research workers must be able to pursue their investigations beyond the chemical laboratory and the experimental animal, to include the study and observation of disease in humans. Conversely, observations on patients must be taken to the laboratory for evaluation.

This need was not so acute in the study of the epidemic diseases. With them, it was possible to go into the affected areas and observe patients in their homes and communities. With diseases such as cancer, arthritis, or cerebral palsy, however, the observation of patients must be under controlled conditions, and over long periods of time.

As long ago as 1911, the Surgeon General expressed in his annual report to Congress the wish that the Public Health Service's Hygienic Laboratory (as NIH was then called) might have "a hospital attached to the laboratory to which patients suffering from a particular disease which it is desired to study could be admitted, so that the cases could be studied throughout all stages of the disease." But it was not until 1947, under the 80th Congress, that a clinical research facility at the National Institutes of Health in Bethesda was finally authorized. This structure, named the Clinical Center, is now virtually completed and ready for research use.

The Clinical Center is a combination laboratory and 500-bed research hospital. It has been designed and constructed with the greatest of care to provide specialized opportunities for integrated research—in which the laboratory scientist, the clinical researcher, the clinician, and their many supporting personnel work as teams.

The clinical center is not another new research program in itself. Rather it is a resource, a central service to facilitate research programs by providing patients and by giving them the best possible care while they are under study.

You may be interested to know some of the plans for clinical-center operation. The patients will be referred by physicians and chosen on the basis of the relevance of their disease condition to the research problems under study at NIH. Medical schools, hospitals, and practicing physicians will not only refer patients for study but, through consultation, followup treatment, and observation, will actively participate in these studies. The clinical center facilities will be open to distinguished visiting scientists for collaborative or independent studies. The center will provide space for elements of the research programs of all seven Institutes of the National Institutes of Health, with patient-bed allocations varying according to their needs. It will draw upon the medical profession in the greater Washington area for

consultants. In every way possible, it is being planned to contribute to the advancement of medical science on a national scale in close cooperation with the medical profession.

The Public Health Service—and, indeed, the whole of the medical research world—has great hopes for the clinical center. It is a facility which will give our scientists the space, tools, resources, and intellectual and organizational climate to achieve maximum productivity in the search for new knowledge to combat disease in man.

Some of the key staff, much of the equipment, and all of the plans are ready for the clinical center to open. We hope to bring patients into the center in the near future and gradually build up to full occupancy over a period of years.

SUPPORT OF RESEARCH

Three-quarters of the money appropriated to the National Institutes of Health is distributed in the form of grants to support research, the training of research personnel, and the construction of research facilities. These funds are made available to investigators in medical schools, universities, hospitals, and other non-Federal institutions and laboratories.

Since 1947, 7,362 separate studies conducted in 386 research institutions in every State in the Union have been supported. We consider it extremely significant that private groups and individuals have increased their direct contributions to medical research while Federal support was growing. This is fundamentally a healthy situation in that an expansion of Federal aid in a field vital to the Nation has stimulated rather than replaced private contributions.

The procedure for deciding what studies and what investigators shall be supported by grants has been very carefully planned to insure four things: That the best scientific judgment of the country is brought to bear on decisions; that the broad wisdom of laymen is balanced against scientific judgments; that research support is equitably distributed to both large and small institutions; and that the whole process is impartial. The most important single way in which these objectives are reached is through the extensive use of advisory groups. No grant may be approved by the Surgeon General until it has been recommended by 1 of 7 national advisory councils. In addition, there are some 20 technical panels called study sections, containing roughly 200 of the top scientists in the Nation who advise on the merits of individuals and research proposals.

The net result of these advisory processes is to diffuse the decision-making process in a Federal program throughout the scientific and lay community. By establishing the advisory councils, which are set up by law, Congress has resolved some of the most important dilemmas inherent in keeping this Federal function close to the people.

The return on this medical-research investment has been tremendous. About a quarter of all published medical-research findings from all medical schools since the end of World War II have come from studies financed in whole or in part from Public Health Service grants.

The acute and growing shortage of scientific manpower for America's needs has been recognized in our total program by our support of research fellowships and traineeships. Since its inception, 2,914 fellows and 3,641 trainees have received whole or partial support from

NIH. Over 90 percent of all these young scientists have entered into various phases of medical research, and a gratifying percentage remain in research as a life work. It has been a privilege for us to guide these training activities so that some of the best scientific and medical brains of the Nation are made available for the vitally important research functions.

In addition to research grants and fellowships, portions of the funds appropriated to the National Institutes of Health are spent in programs of teaching grants to medical schools and in aid to States for specialized disease-control programs. From 1948 through 1950, grants were awarded to support the construction of research facilities; and, although such funds have since been curtailed, there is still a serious inadequacy of physical facilities in which to conduct medical research.

RESEARCH ORGANIZATION

I have talked about the general nature of NIH programs and specifically about the clinical center and our grants activities. Seven of these programs are research institutes; in total, they are concerned with all of the major diseases of today. Each conducts certain of the grants activities, each conducts its own research in existing laboratories at NIH, and each will redirect its program as the resources of the clinical center become available.

You will have an opportunity to hear from and ask questions of the Institutes Directors later in these hearings. They will want to tell you about their programs. I would like to clarify now, before you meet with them, the way we are organized to conduct our research. You have before you 8 appropriation items which together represent NIH's total budget request for fiscal year 1954: 1 general appropriation for NIH, and 1 for each of the 7 Institutes—Heart, Cancer, Mental Health, Dental Research, Microbiology, Arthritis, and Neurology and Blindness.

The first of these—the one labeled "Operating expenses, NIH"—is the one to which I wish to speak. It consists of funds for the operation of the Division of Research Grants and for the support of certain grants which by their nature cannot be identified with the field of any one Institute.

One technical matter relating to the budget should be explained at this point. To promote efficient and economical operation, we centralize certain research services, notably patient care and related activities in the clinical center, and other service units directly involved in the conduct of research. If each Institute attempted to provide these services for itself, costs would increase substantially. So, each Institute in effect buys these research services from a central source out of its own budget. This is why the budget materials for each Institute show a reimbursement item to "Operating expenses, NIH" to pay for such services.

As indicated earlier, the clinical center is a central facility for the use of all Institutes. It provides everything necessary for the care and welfare of patients, and furnishes certain clinical services to the Institutes. It does not do research itself on disease. Since it is a service facility, each Institute pays a pro rata share of the cost of its patient activities. It is financed entirely by reimbursements from the Institutes' appropriations.

In the same manner, the central NIH appropriation is reimbursed by the Institutes for many other service operations required to carry on research—the provision of experimental animals, specially designed laboratories (such as those required for the safe conduct of high-energy radiation studies), construction of highly specialized equipment and instruments, preparation of culture media, library, personnel, budget and supply activities, and so on. We have found that these services, too, must be centralized in order to make maximum use of staff and facilities.

BUDGET INCREASES

The increases in this total NIH budget for fiscal year 1954 over the appropriation for current fiscal year may be summarized as follows:

1. Increase in grants designed to meet the research needs expressed by the Nation's medical schools and universities.
2. Funds for the first full year of operation of the clinical center.
3. Increases in clinical-laboratory research in two Institutes which are just getting started in their laboratory programs—the Neurological and Blindness Institute, and the Mental Health Institute.

In making this request, I clearly recognize that support of increases for medical research in the face of the need for broad economies in Government would be a special manifestation of your recognition of the great importance of our work to the national welfare.

The effects of disease—measured in both human and economic terms—are a substantial burden on national strength, productivity, and economy. Sustained national support for research, insistent effort to bring research knowledge to the point of application, and broad programs to ensure that the medical and public-health professions apply that knowledge are national investments that have been proven to pay high dividends.

EXTERNAL RELATIONSHIPS

I would like to mention some of the ways in which our work is linked with that of other governmental, private, and voluntary agencies in the health field. Our grants and technical-assistance programs make us important to the national research picture. Many of our scientists have achieved national and international stature. The top award of the American Chemical Society in the field of enzyme chemistry—sought after by all the industrial, university, and governmental laboratories in the country—has been won the last 3 years in a row by 3 different enzyme chemists from the National Institutes of Health.

We have just lost one of these award winners to Washington University in St. Louis, where he will become head of a department. Dr. Norman Topping left us last fall to become vice president of the University of Pennsylvania. Dr. Shannon, Dr. Topping's successor, came to us from the Squibb Institute for Medical Research, where he was research director. This kind of interchange of professional staff indicates a healthy relationship between our laboratories and the rest of the world of medical science.

But organizational interrelationships are important, too, if we are to help Government make effective and economic use of all the health

resources available in this country, and if we are to do our part in helping maintain balance between Federal and non-Federal programs.

We have active cooperative relations with the Atomic Energy Commission, the Department of Defense, the Department of Agriculture, the Federal Civil Defense Administration, the National Science Foundation, and the National Research Council. This cooperation involves research projects of great importance, such as studies on the effects of radiation on humans; the development and testing of new drugs of importance to medical care in Korea; research seeking a new and cheaper source of cortisone; studies involving defense against biological warfare; and participation in programs involving the licensing and allocation of gamma globulin.

Outside of Government, we have established particularly successful relationships with the many voluntary health agencies and foundations, each of which has an interest in a specific health field. These are most important, since our programs must supplement rather than duplicate each other. Representative of this type of organization are the American Cancer Society, the American Heart Association, the Arthritis and Rheumatism Foundation, and so on.

I would like to conclude my remarks by emphasizing the meaning of medical research to America's future.

The Nation's medical research effort—in university and medical-school laboratories and in governmental and industrial laboratories—is for the first time in our history approaching a scale commensurate with the magnitude of the problems of disease.

Given the continuity and stability that are indispensable to productive research, it is virtually certain that in the years ahead the scientists of this country will bring progressively under control these diseases that are now the mass killers and cripplers.

Our laboratories are a part of this national effort, and we are conscious of the heavy responsibility we bear in supporting a large share of medical research in medical schools and universities.

In these times of uneasy peace, much of our national income must be devoted to the apparatus of war, and we live in a time of apprehension. Through these difficult years, we trust that medical research will be sustained not only as an economically sound policy, but as a symbol of faith in the future.

Mr. Chairman, I would like to introduce to you and to the committee Dr. Shannon, whom I mentioned, who sits here on my left. He has taken Dr. Topping's place, who you may remember was the associate director. Dr. Van Slyke, sitting at the end there, used to be the director of the Heart Institute.

Mr. BUSBEY. Yes, I remember Dr. Van Slyke was the director at the time we visited the institute a year or two ago.

Dr. SEBRELL. He is now in charge of our extramural affairs, and we have brought in a younger man to be head of the Heart Institute. Dr. Van Slyke moved up to larger responsibilities.

Mr. BUSBEY. Thank you, Dr. Sebrell.

DELAY IN OPENING OF CLINICAL CENTER

Toward the bottom of page 4 of your prepared statement you state:

> This structure, named the Clinical Center, is now virtually completed and ready for research use.

Do you have anything in writing from the Bureau of the Budget telling you that you cannot hire personnel to open this center?

Dr. SEBRELL. We have the directive which was received by the Federal Security Agency to the effect that we could not operate at a level exceeding the January rate of expenditure and that we could not hire additional personnel. There is no direct statement that we could not open the clinical center, but the restriction in the February 3 letter from the Director of the Bureau of the Budget had the same effect. Since we were just about ready to open, those general provisions just happened to catch the clinical center. We cannot comply with the provisions concerning the January rate of expenditure and the limitation on hiring new people and get the clinical center opened. So it just happens that unfortunately this is one of the few places in Government where that particular provision caught us at an unfortunate time and happens to have operated in that way.

Mr. BUSBEY. Do you have the memorandum with you?

Mr. STEPHENS. No, sir.

Mr. HARLOW. Mr. Chairman, there was another letter from the Director of the Bureau of the Budget, when the Administrator notified them that she was going ahead with the opening of the clinical center, in which the Director suggested that we not open until the final considerations had been had with respect to the 1954 budget. There was no order; there was a suggestion in writing.

Dr. SEBRELL. That was a suggestion, Mr. Chairman, from the Director of the Budget, and I may say a very reasonable one, because until we establish the level of operation of the clinical center for the fiscal year 1954 it would be unwise to admit a number of patients and open at a certain rate, unless we knew where we were going during fiscal 1954; so awaiting the establishment of the 1954 level, as suggested in this communication from the Director of the Budget, was wiser than trying to open it now.

Mr. BUSBEY. This was sent to the Administrator in the form of a written suggestion?

Dr. SEBRELL. Yes, sir.

Mr. BUSBEY. What was done to call the attention of the Bureau of the Budget to the fact that this clinical center is in a rather special category so far as personnel is concerned, inasmuch as we have spent over fifty millions of dollars to build this center over a long period of time? I do not know how the other members of the committee feel, but I am sure that they would be in sympathy with my viewpoint that, after investing all this money, we should not delay a single day in making use of the center.

Dr. SEBRELL. As Mr. Harlow indicated, Mrs. Hobby wrote the Director of the Budget to the effect that she intended to go ahead with opening it and the Director of the Budget wrote back and suggested further delay until the 1954 budget was decided. So far as I know there has been nothing further since that time.

OFFICIAL COMMUNICATIONS RELATING TO OPENING OF CENTER

Mr. BUSBEY. I would like to have copies of those communications entered in the record at this point.

Mr. STEPHENS. There really would be three. There would be the Budget's general letter after the change of administration about the

January rate of hiring, the Department's waiving of those provisions as far as the Institute was concerned, and then the third communication, a letter from the Director of the Budget suggesting that we wait until the level of the 1954 operations was determined. So there really would be three of those communications.

(The letters referred to follow:)

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D. C., March 9, 1953.

Hon. OVETA CULP HOBBY,
Administrator, Federal Security Agency, Washington, D. C.

MY DEAR MRS. HOBBY: I have your letter of March 2, 1953, advising that you find it necessary to approve the recruitment of personnel in anticipation of the opening of the Clinical Center of the Public Health Service on April 1, 1953.

It is my opinion that we should try to avoid any immediate administrative actions which will curtail our discretion in planning for 1954 expenditures. In the review of the 1954 budget, the Bureau of the Budget will wish to explore every practical possibility for carrying on necessary activities at minimum cost, and in the case of the Clinical Center one approach would be to reconsider the opening date and the rate of buildup of operations. Obviously, if the facility is opened according to the present schedule, the costs for operating the Clinical Center in fiscal year 1954 would be substantially greater than if the opening were delayed.

Therefore, in view of the effect of your proposed action on the 1954 expenditures for the Clinical Center, I would suggest that the decision to hire additional personnel at this time be postponed until a firm decision has been made on the 1954 budget. It seems to me that this would be the prudent course of action and will not entail a material delay, since decisions on your budget for 1954 must be made very quickly.

Sincerely yours,

JOSEPH M. DODGE, *Director.*

FEDERAL SECURITY AGENCY,
Washington, March 2, 1953.

Hon. JOSEPH M. DODGE,
Director, Bureau of the Budget, Washington, D. C.

DEAR MR. DODGE: This is in connection with your letter of Feburary 4, 1953, in which you set out the policy of the administration looking toward the accomplishment of a balanced budget. It occurs to me that the conditions enumerated in your letter under "With respect to personnel" and in regard to expenditures above the January rate of operations are subject to exception in the opening of the Clinical Center of the Public Health Service at Bethesda.

The Government has invested approximately $70 million in the new facility. Plans formulated when the 1953 budget was in preparation contemplated the opening of that Center on April 1, 1953, with a progressively increasing number of patients up to 150 by June 30, 1953. Obviously employees cannot be secured for utilization under this schedule without waiving to some extent the hiring of new personnel, nor can the Center be opened as scheduled and operated with funds restricted to the January 1953 obligation level. I have, therefore, approved the recruitment of personnel to open that Center on schedule (April 1) and at the level originally conceived. Such opening will not entail deficiency spending. The 1953 appropriation was made on the basis of expenditures at an uneven rate throughout the fiscal year—that is, heavier in the fourth quarter.

Sincerely yours,

OVETA CULP HOBBY, *Administrator.*

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington D. C., February 3, 1953.

Hon. OVETA C. HOBBY,
Administrator, Federal Security Agency, Washington, D. C.

MY DEAR MRS. HOBBY: One of the first and most important tasks of our new administration is to review the 1954 budget and to proceed toward the accomplishment of a balanced budget.

This review will take the initial steps toward that goal; will establish in definitive form how far we can go in that direction in the fiscal year 1954; and set the stage for the fiscal year 1955. It should help to identify issues that will be significant in the formulation of the budget for that year.

The problem is complicated by inheritance of the costs of a Federal debt of more than $265 billion; indicated deficits for the fiscal years 1953–54 totaling $15.8 billion; and accumulated unexpended balances of appropriations in excess of the total new obligational authority requested for fiscal year 1954.

It is clear that this situation will not be brought under control without action to reduce budgetary obligational authority, reduce the level of expenditures, critically examine existing programs, restrain commitments for new programs, and generally to drive for greater efficiency and reduced costs.

In this review the policies shall be as follows:

With respect to personnel.—It is the policy to reduce the number of Government employees. Each department or agency head shall immediately restrict the hiring of additional personnel. No vacancies shall be filled until the department or agency head shall have determined to his satisfaction that—

(*a*) The positions represented by vacancies cannot be eliminated.

(*b*) Existing employees cannot be shifted to cover the vacancies.

(*c*) Increased efficiency, better utilization of personnel, or changes in standards and policies of department or agency operation will not make possible the attainment of (*a*) and (*b*) above.

It is the policy to achieve a progressive reduction of personnel for the remainder of the fiscal year 1953 and for the 1954 budget. Variations from this policy, as applied to individual departments and agencies, will be granted by the President in his review of the 1954 budget only upon specific request and adequate justification by the department or agency head.

With respect to construction.—It is the policy to proceed only with those projects which are deemed clearly essential in terms of the objectives of this administration and on such projects to employ the strictest standards of economy. Each department and agency head is therefore directed to:

(*a*) Review all proposed or authorized construction projects on which work has not yet begun, and to propose initiation of construction during the remainder of the fiscal year 1953 and the fiscal year 1954 only on those projects which he determines meet the above criteria.

(*b*) Review all going construction projects in the light of the above criteria and take such action as he may deem appropriate, including action to stop the work.

With respect to all programs.—It is the policy to operate at a minimum level of cost and expenditures. This policy requires that the necessity for all work be questioned and that action be taken to eliminate unnecessary programs and to hold the remainder to minimum levels. Each department and agency head is therefore directed to—

(*a*) Permit no increases over the January rate of obligations except on complete justification and specific approval, unless such increases are clearly necessary to meet requirements fixed by law.

(*b*) Initiate an immediate review within his department or agency calling for recommendations on the downward adjustment of program levels and for information as to the probable effect of such adjustments on Government services.

The results of these reviews should be used wherever possible in the 1954 budget revision procedure and in the preparation of submissions for the 1955 budget.

You are expected to translate these guides into proposals for specific revisions of the budget figures for your department or agency and to transmit them to this office in the form indicated in the attachment. Your proposals should be received by this office on or before March 2, 1953.

Pending the receipt of your recommendations and the President's decisions on proposed revisions of the 1954 budget, any significant deviation from these policies and criteria shall be reported to the Bureau of the Budget.

Your recommendations pertaining to the 1954 budget also should indicate the possibilities of making further changes in subsequent budgets where you propose that legislation now in effect be amended or repealed. Where your budget review indicates the desirability of a change in legislation, a draft bill or other proposal for action should be submitted for appropriate clearance as promptly as possible.

Legislative proposals, originating either in Congress or in your department or agency, which would affect financial requirements of your department or agency, should be reviewed in the light of the budget policies set forth above.

The recommendations which you make in response to this letter, like all other budget estimates, are in the nature of advice for the President, and are highly confidential prior to the time that the President formally has acted thereon.

Sincerely yours,

JOSEPH M. DODGE, *Director.*

LOSS OF TIME FOR UTILIZATION OF CENTER

Mr. BUSBEY. What is the amount of time loss in opening the clinical center due to this "hold" order from the Bureau of the Budget?

Dr. SEBRELL. We had originally planned to begin to take patients on the 1st of April. That date was later moved to the 20th of April, and the building is now physically ready to take patients, with the exception of a few pieces of equipment which probably will be delivered this weekend. Because of the necessary time consumed in hiring large numbers of people—you see, we will have to hire some 300 additional people to get started; they are people such as food handlers, nurses, and the people necessary for caring for patients—we estimate, moving as rapidly as our resources will permit, it will take approximately 60 days from the time we get released from the inability to move ahead until we can actually safely take the first patient. So if this were released tomorrow or, say, the 1st of April, I do not believe it would be physically possible for me to take patients before the 1st day of June. We might shave a few days off of that by working overtime and things of that kind, but these people have to have a certain amount of training before we dare turn them loose with patients. So I would say the time loss would be the time between the middle of April and whenever we actually get open.

Mr. BUSBEY. Frankly, I feel very keenly about this. While I look at it the same as you people at the National Institutes of Health, that is, from a scientific and medical standpoint, I also look at it from a business standpoint. Having been in the investment business ever since 1920, I cannot help thinking of the interest of this tremendous investment and of what is being lost every day that this clinical center is not open.

Dr. SEBRELL. That is certainly true, Mr. Busbey. While it will show a dollar saving by every day we do not open in the money in this year's appropriation, it is a loss on the total investment.

Mr. BUDGE. In connection with the question you asked a few moments ago, I wonder if the Public Health Service has gone as far as it might in inviting the attention of the Bureau of the Budget to the fact that this is an unusual circumstance. Is there anything further that could be done to point out that factor to the Bureau of the Budget?

Dr. SEBRELL. I have been as vigorous as I can. I think the Administrator has been fully behind us on this and, in the present cir-

cumstances, as far as I understand it, it is dependent now on the final word on the 1954 budget.

Dr. DEARING. Right on Mr. Budge's question, I know the Administrator is sympathetic in that she tried to get this off the ground and did send the original notice to the Director of the Budget that she thought this important enough to go ahead and make an exception to the freeze on the January rate of obligation. And since the Director of the Budget asked that we delay until the final determination on the program was fixed, we have furnished her another statement of precisely what it means in time, including the 60-day-leave period Dr. Sebrell mentioned after we start getting the working staff on the job.

Mr. BUDGE. Was the letter you furnished rather recent?

Mr. DEARING. Fairly recent. I do not recall the exact date, but it is fairly recent.

Mr. BUDGE. I mean within the last week or so.

Dr. DEARING. Within 2 weeks or so. I am not sure whether it was last week or not.

Mr. BUSBEY. For the record, this is not the first time I have taken issue with the Bureau of the Budget, although I must confess it is generally on the other side of the fence. I just cannot see any justification for the stand of the Bureau of the Budget. It appears to me that it is going to mean a minimum delay of 2 or 3 months in getting the personnel necessary to open this center.

GRANTS FOR RESEARCH

Now, on page 6 of your statement, Doctor, you say:

> Three-quarters of the money appropriated to the National Institutes of Health is distributed in the form of grants to support research, the training of research personnel, and the construction of research facilities.

Are you reducing the amount requested for grants commensurate with the increase in research that you will be doing at the new clinical center?

Dr. SEBRELL. No; we are not, because the two things are not related. The increase of research at the clinical center we look on as a new addition to the medical research facilities in this country and not as a substitute or replacement for work now being done in universities and medical schools. And from the requests we have for separate research, it is our feeling that research in medical schools and universities needs further support over the support it has today as well as the addition of the clinical center facility to our research resources.

QUANTITY AND QUALITY OF RESEARCH

Mr. BUSBEY. Of course, participating universities could spend all the money they could get in their research programs, but what about the personnel who benefit by and work under these grants? It seems to me that the more fellowships and the more people you bring into this grant training and research program, the level of accomplishment per unit of funds expended would tend to be lowered. Would you comment on that?

Dr. SEBRELL. If I understand your question, Mr. Chairman, these fellows, the men who come into research, are very well qualified to

pursue a research project when they finish their fellowships. And while they may spend a year or two as an assistant or associate with someone on a program, they very quickly branch into wanting to develop their own ideas and follow their own research interests. And they are fully capable of doing it if they can get the place to work.

Mr. BUSBEY. Are more men going into medical research every year as a result of the program?

Dr. SEBRELL. I would like to ask Dr. Van Slyke for an opinion on that point, Mr. Chairman. He is very familiar with the whole medical-research field.

Dr. VAN SLYKE. I am sorry I do not have specific figures, but there is an increase in the number of persons who are being trained to carry on independent medical research. This training is supplied not only by the Federal Government, not only by the universities with their own funds, but by large contributions from private sources, and also from industry there is a rather large number of research fellowships made available now. So that the sum total of persons qualified to expedite medical research is increasing year by year.

Mr. BUSBEY. I just wondered how that increase would affect the quality of the men going into research.

Dr. VAN SLYKE. If I may comment on that, I should like to offer the fact there is tremendous competition for these training places and, frankly, my experience has been that the quality has been steadily increasing, particularly since World War II days. We see it in the people we pass judgment on by their research fellowship applications. The quality has gone up tremendously.

I think we should all be heartened by the fact that people of such enlightened ability and promise are taking an interest in this field. As you well know from private work in the financial field, it does not pay the money other fields do.

Mr. BUSBEY. I am frankly very heartened, also, by your comments about the quality of these individuals.

Dr. VAN SLYKE. That is the same attitude we had when we first started this research program following World War II. We thought as funds became available it would lessen quality. Much to our surprise and much to our satisfaction, it has gone just exactly the opposite way.

You probably noticed in the newspapers within the last 3 weeks that several foundations have increased their research grants. John and Mary Markle Foundation just the other day announced a series of $6,000 awards to get more people into medical research.

COLLEGES AND UNIVERSITIES RECEIVING RESEARCH SUPPORT

Mr. BUSBEY. On page 7, Dr. Sebrell, you mention that—

Research support is equitably distributed to both large and small institutions.

At first glance that seems to indicate that distributing money equitably to everyone is more important to you than getting research done. What difference does it make if every penny goes to large institutions, or vice versa, as long as those that get the money are best qualified to do the job?

Dr. SEBRELL. We feel that makes a lot of difference. While it may seem that way at first glance, the essential difference is this. Most of

the research facilities and big apparatus and big names and so forth are centered in the northeastern part of the United States—and that naturally is where the bulk of our money goes. But many small institutions have men in them who are capable of doing research and who would like to do research. The quality of their teaching would be improved, the quality of their students would be improved, the men they turn out would be better trained men, if the professor were engaged in some research project. But those small institutions are most likely to be in the greatest financial difficulty.

We do not mean to compromise the quality of the research. The men still must come up with an understandable research plan. But if we can give the small institution some research money, we think the students, or more of the students, from these small institutions would be exposed to the problems of medical research and their minds would be stimulated and we could get men going into research from areas in this country which now produce very few of them, we feel, because they never have a chance to learn what research is or to get their minds stimulated by seeing the professor working on some research problem.

I personally feel it would be a very great mistake if all Federal research funds were channeled to our big institutions which have large investments and large groups of people working on research. After all, some of our great discoveries have come from men working by themselves in out-of-the-way places, and you never know when a really brilliant idea is going to turn up in an unusual place. I think we should stimulate that a little bit, too.

Dr. VAN SLYKE. May I comment a little further on that, since we have made an analytical study of what we refer to as "equitable distribution"? If we draw the line across the paper from the lower left-hand side to the upper right-hand side, we can show the ability to do research along this line is matched almost directly by the amount of funds which these institutions get. We have a prepared paper on this. If you wish, we can supply that for the record, several sheets long. But it does show the ability to do research is matched by the grants made to institutions.

Mr. BUSBEY. I do not think that is necessary, but I am sure that you did not wish to leave the impression with the committee that the grants were distributed on the basis of a numerical division between the large and the small institutions.

VOLUME OF PUBLISHED MEDICAL RESEARCH FINDINGS

Similarly, I am a little concerned about the impression that may be left with the committee by the statement toward the bottom of page 7 that—

> About a quarter of all published medical research findings from all medical schools since the end of World War II have come from studies financed in whole or in part from Public Health Service grants.

You do not want to leave with the committee the impression that we are measuring progress in terms of the volume of printed matter, I am sure.

Dr. SEBRELL. That was not our intention, but that was gathered from our own study of the articles appearing in the scientific journals.

And it is these reports that furnish one measure that we are getting something for our money—that is, a written report on what the man did. And it was our intention merely to show that point.

Dr. SHANNON. That is really a fairly objective measure, because the published paper must go through the hands of at least two editors and be considered suitable for publication in a scientific journal before it is published. So each of these judgments is really the judgment of scientific editors rather than our own as to the worthwhileness of a piece of work.

1954 PROGRAM FOR OPERATION OF CLINICAL CENTER

Mr. BUSBEY. In regard to "Budget increases" on page 10 of your statement, you refer in item No. 2 to "funds for the first full year of operation of the clinical center." It is obvious that if you do not get started within the next few weeks, it is going to be impossible for you to get into full operation for the entire period of the fiscal year 1954.

Dr. SEBRELL. If by that you mean a full 500-bed operation, I think that certainly is true. How far we will be able to go depends, first, on when we start and, secondly, how rapidly we build up. The conventional buildup will be determined, I feel sure, by the amount of money available. If we could build the clinical center up to somewhere in the neighborhood of 300 beds instead of 500 in the first full year of operation; that is, if we could come to July 1 of next year having gone up to around 300 beds, I would think we had done a very good year's operation, because there are many unforeseen problems in this clinical center. There has never been an operation like this before. We have to study every operation we do, and we cannot forecast what the cost of many of these things is going to be. We will have to come in next year and show you this cost and determine what the operation should be, because we just have no experience anywhere on which to make final judgments. We are making intelligent guesses with the aid of every bit of advice we can get from all of the big hospitals and the organizations we can consult, but I would feel very well satisfied if we could operate this center starting from no beds, whenever we can open—either the 1st of June or the 1st of July—and aiming at a maximum of 300 beds by the end of this fiscal year. This, in my opinion, would give us plenty to do.

PROJECTED TIME SCHEDULE FOR FULL OPERATION

Mr. BUSBEY. Have you projected a time schedule that you would like to see met for bringing this clinical center to full operation?

Dr. SEBRELL. We project such a timetable in connection with this present budget. The timetable I have in front of me foresaw 150 beds occupied by July 1 of this year and going from that to 300 in June of 1954 and eventually going up to 500 beds at some later time. We cannot now have 150 beds in use by July 1 of this year; that is no longer possible. But I think we possibly can make that up by accelerating our rate of acquisition during the year and still reach 300 beds as of June 1954 which is the present schedule. So I would have to recast this whole schedule that I have laid out here at a much faster rate. I feel reasonably sure we can do that.

RATE OF ADMISSION OF PATIENTS AFTER CENTER OPENS

Mr. BUSBEY. It seems to me that you would run into some rather complicated problems in trying to accelerate after July 1 in order to meet any previously established timetable.

Dr. SEBRELL. Yes, sir.

Mr. BUSBEY. Because you will have some rather ticklish problems to solve in regard to the acceptance of patients in the clinical center.

Dr. SEBRELL. I think with the groundwork we have laid out, we will in the first few months of operation very easily secure a fairly large number of patients. You see, we have now patients that we could move in within a matter of a few days, and I think when we open we can possibly speed up very rapidly to something of the order, perhaps, of as many as 90 or 100. Then we will level off for 2 or 3 months and get some experience with that number, solve some of those basic problems, and then move forward with another number. As we go along, they are going to be more and more difficult to get. The first 100 we have will be easy, because we know where to obtain them, but securing the rest of them will be more difficult. I do not know whether we are going to have a flood of applications from people we cannot handle or whether the thing will work smoothly. I think this is a good number to open with, and after a little leveling off for experience we can well go forward well enough to reach 300 beds without difficulty.

SCHEDULE FOR ADMITTING DIFFERENT TYPES OF PATIENTS

Mr. BUSBEY. Do you contemplate moving patients into the center for all types of research activity you cover at the National Institutes of Health, or do you have certain types of patients picked out, such as cancer and heart victims, that you will move in first, and then add the other types as you go along?

Dr. SEBRELL. Yes; that is what we will do. We will open by activating individual nursing units. The nursing unit will constitute at least 15 or 16 beds. The first unit will be cancer patients, and the next unit will be from some other institute, so that we will gradually take on patients for each research institute in line with a schedule for opening the units.

Mr. BUDGE. Doctor, as I understand this problem, the purpose of having patients at the center is to have them serve as a part of the team in medical research.

Dr. SEBRELL. That is right.

Mr. BUDGE. And your objective would not necessarily be the occupancy of so many beds but, rather, the provision of facilities to take care of the types of cases which you wish to observe.

Dr. SEBRELL. That is it exactly.

Mr. BUDGE. Under that system you would not be working toward the occupancy of a specific number of beds at a particular calendar time.

Dr. SEBRELL. You see, we have, for example, the projects picked out in cancer here, and the first group of beds to open will be cancer beds, and we will open one nursing unit, because that is the conventional organizational unit, and anything less than that is not practicable. And then all of those patients will be in the research study, and the

laboratory men and everything will go with those patients to that particular study.

Then we will open a group of beds in another institute, and they will have the laboratory men and the clinical men. The second institute we actually scheduled was to be the mental-health institute.

The next group, therefore, will be psychiatric patients, and then we will go to the group with heart disorders and so on, with everything that goes with them, to carry on that particular study.

We are not just treating patients in the ordinary sense. We are trying to obtain particular patients. They are highly selected because they have certain diseases and are ready for study. So, the whole thing will go together in a unit.

Mr. BUDGE. That is my understanding; that you are not trying just to fill a hospital.

Dr. SEBRELL. Oh, no; not at all.

It is much more complicated than just taking patients.

Mr. BUDGE. It should be.

Dr. SHANNON. I think it must be appropriate. We have been building the staff for this clinical-center operation for roughly 3 years, and the 300-bed figure is something arrived at with real program knowledge. It is something we arrived at in connection with institutes who are familiar with the details of their program. Three hundred is the minimum number of patients to carry on an effective program—not the minimum number needed to carry on the total comprehensive program but the minimum number for an effective program.

Mr. BUDGE. That is, they will be the people with the particular illnesses which you desire to study?

Dr. SHANNON. Yes, sir.

1954 BUDGET ESTIMATE COMPARED TO 1953 APPROPRIATION

Mr. BUSBEY. Your budget request for 1954 is $5,180,000.

Dr. SEBRELL. That is correct.

Mr. BUSBEY. That is $11,418,750 below the amount appropriated last year.

Dr. SEBRELL. Yes.

Mr. BUSBEY. But for 1954 the major part of the work is being shifted to other appropriations, and taking these transfers into consideration the appropriation request is $169,650 above the comparable amount appropriated in 1953. Is that right?

Dr. SEBRELL. Yes, sir.

FUNDS REQUESTED OF BUDGET BUREAU

Mr. BUSBEY. For what did you originally ask the Bureau of the Budget?

Mr. STEPHENS. The original request, including the B item of $989,000, was $6,000,000 after the transfer.

GRANTS FOR RESEARCH

Mr. BUSBEY. You are asking for $4,500,000 under this appropriation for research grants?

Dr. SEBRELL. Yes, sir.

Mr. BUSBEY. Which makes an increase of $245,000 over 1953; is that right?

Mr. SEBRELL. Yes, sir.

Mr. BUSBEY. Dr. Sebrell, would you tell us a little more about the type of research done under grants from this appropriation? What have been some of the tangible results of such research during the last year?

Dr. SEBRELL. I will ask Dr. Van Slyke to answer that, as he is intimately familiar with this research.

ACCOMPLISHMENTS OF RESEARCH PROJECT PROGRAM

Dr. VAN SLYKE. The $4,255,000 available for research grants this year goes to support 478 research projects at institutions around the country. These research grants do not include fields which have special support, like heart, cancer, and mental health.

An example of the type of work which these funds have supported is the work connected with the influenza studies. We have had a series of national studies, as a matter of fact, in cooperation with others and really international because of the laboratories that are studying the influenza organism, and actually they are the watchmen for the type of influenza which we remember was unfortunately so severe in 1917 and 1918. So if an epidemic breaks out any place in the world, we are prepared to capture that organism and put that organism into mass vaccine production.

Another type of activity which this fund supports is the studies relating to the use of ACTH and cortisone that we reported about to this committee before.

A third type of activity which this supports is our research studies on gamma globulin and related products. You notice the interest in the newspapers about gamma globulin as a possible preventive for infantile paralysis.

I would be pleased to supply more adequate information for the record, if you would like, but it is the type of thing that these funds for the National Institutes research grants program supply.

Mr. BUSBEY. If it would not be too much trouble, more information on that program would be helpful to have in the record.

Dr. VAN SLYKE. I will be glad to supply it.

(The information is as follows:)

MEDICAL RESEARCH RECEIVING SUPPORT FROM THE DIVISION OF RESEARCH GRANTS, NATIONAL INSTITUTES OF HEALTH

Before going into detail on the accomplishments of this program, it may be appropriate to point out briefly its background.

During World War II, when our total national effort was geared to survival and ultimate victory, the Government placed considerable emphasis on the support of expanded activities in the field of medical and biological research and planned for the administration of this program by establishing the Office of Scientific Research and Development.

In 1946, when the Committee on Medical Research of the OSRD sought to liquidate its program, the responsibility for approximately 50 research projects of continuing peacetime significance was transferred to the Public Health Service. This action touched off a rapid expansion of research grant activities, and research in this field entered an era in which medical research received increasingly wide support.

The continuation and expansion of this program has been consistently validated by the Congress of the United States through its actions on the Public Health Service's annual appropriations to support medical research programs.

At the very outset, the Public Health Service decided to place the responsibility for the scientific evaluation of all research grant applications in the hands of nongovernmental scientists who are expert in the areas concerned. The Public Health Service is deeply grateful to these 275 scientists for the long hours they have devoted to the burdensome scrutiny of research grants applications from all parts of the country.

The great bulk of the research grant applications received by the PHS fall into the broad categories of research covered by the seven institutes of the National Institutes of Health.

There are, however, some projects which do not fall clearly within the research province of any specific institute. Many of these studies relate to basic phenomena common to all diseases and vitally important to all of medical research, but not clearly related to any one group of diseases. The essential function of grants financed through the Division of Research Grants of the National Institutes of Health is to provide a source of funds for research of this essential type.

Examples of research in the area of general public health techniques are as follows:

1. Analysis of sewage and industrial wastes.
2. Organisms involved in activated sludge process and sewage.
3. Evaluation of health education activities.
4. Quality of medical nursing care.
5. Sulfur compounds in sewage treatment processes.

Examples of investigations in basic research areas not directly related to any specific group of diseases are as follows:

1. Studies on the optical properties of muscle.
2. Synthesis of cortisone from sterols.
3. Effect of hormones on capillary permeability.
4. Vitamins in the synthesis of fatty acids.
5. Total synthesis of morphine.
6. Heat balance in premature infants.
7. Iron metabolism.
8. Free amino acids in animal tissues.

Some examples of specific recent accomplishments that have grown out of the so-called noncategorical grants program of the Public Health Service are as follows:

1. Dr. E. F. Adolph, of the University of Rochester School of Medicine and Dentistry, Rochester, N. Y., is studying the effects upon the body of sudden changes from normal temperatures to extreme cold and by deprivation of liquids for periods of several days. This study is producing information that will aid in determining what equipment, for example, should be dropped to paratroopers in Arctic regions. The study has revealed, too, that animals deprived of water, and then allowed to drink, will ingest enough to replace their weight loss in a very short time.

2. Since 1946, Dr. Stephen S. Hudack, of the College of Physicians and Surgeons, Columbia University, has been conducting experimental and clinical studies to develop means for replacing joints in limbs and other regions of the body. Progress has been made in the use of plastic elements in the hip, elbow, and shoulder, and plans have been made to extend this work to the ankle and knee.

3. The treatment of shock from loss of blood and other effects of severe injury is being studied by Dr. Robert Elman, of Washington University, St. Louis. Dr. Elman and his associates have developed a new type of flame photometer—an instrument based on the principle that various substances when burned produce flames with measurable differences. Use of this instrument in examining body fluids from a large series of patients has revealed that shock may be detected while there is still time to prepare for its onset. By means of the photometer, several hundred specimens of body fluids can be analyzed in a day, with a much higher degree of accuracy than was previously attainable.

4. The objective of Dr. V. E. Siler, of the University of Cincinnati, is to work out a chemical method for the removal of skin and subcutaneous tissue devitalized by deep burns. One approach to this problem is through the use of enzymes—naturally occurring organic substances that accelerate various body processes. Studies by Dr. Siler indicate that certain enzymes known to act upon protein substances may remove slough. If studies on laboratory animals prove that devitalized material can be removed by chemical methods without injury to the subject, studies will be undertaken with humans.

5. Outstanding accomplishments in the field of hematology (the study of blood) during the past decade has been achieved by Drs. Edwin J. Cohn, Charles A. Janeway, and a distinguished team of associates at Harvard Medical School. Early in World War II, Dr. Cohn was chiefly responsible for the development of the method of processing blood plasma whereby the Red Cross was able to send tremendous quantities in nonbulky powder form to all parts of the world. The vast research effort involved was financed by sizable grants from OSRD, supplemented by funds from the Rockefeller Foundation, Harvard University, and private industry. Today, the PHS is continuing the support of the brilliant and vital blood research in which Dr. Cohn and his associates are engaged. At present, chief activity centers around a new method of plasma fractionation by means of which it becomes possible to break blood plasma into its component parts. It may be possible, therefore, to transfuse only those components of plasma which are specifically indicated by a particular illness, and thus lessen the chances of bad side effects. Recent developments in this project have made it possible to reduce the size of the equipment necessary for separating the various components of the blood and, also have made it possible to shorten the time for the separation. It is not only possible more effectively to separate the cellular elements from the chemical components of the plasma, but also it is possible to make a better separation of the different types of blood cells, that is, red cells, white cells, and platelets, and to separate more effectively a large number of plasma components, particularly various proteins. These improved separation methods have yielded cellular and protein components useful in basic laboratory and clinical studies leading to an improved understanding of the utilization of blood components.

6. Peptic (or stomach) ulcer has been called the occupational disease of the 20th century. Some physicians believe that peptic ulcers result, in part at least, from the stress and strain of modern living. More specifically, they are associated with continued excess of acid in the stomach. Among those working on the problem is Dr. Keith S. Grimson of Duke University School of Medicine. Dr. Grimson is trying to evaluate types of surgery in treating stomach ulcer. For example, he is comparing results of cutting the vagus nerve (which stimulates production of stomach acid) with results of removing part of the stomach—usually the part which produces acid. He is also testing a new drug, Banthine, which promptly relieves ulcer pain by "blocking" the vagus nerve and thus reducing stomach acids.

RESEARCH ON THE COMMON COLD

Mr. BUSBEY. Are you doing any research on the common cold?

Dr. VAN SLYKE. Right now there is very limited study in that field. We have discussed that with some of the virologists who up to now have been particularly interested in poliomyelitis (infantile paralysis). We are hopefully planning to initiate a much larger research program in the area of upper respiratory infections, which include the common cold. The capture of the organism, for instance, is a long, drawn-out process, because it apparently is a virus organism and, unlike the ordinary organism where you can see the organism, and so forth, it is an extremely difficult one to study.

Mr. BUSBEY. Such diseases as cancer, heart disease, arthritis, cerebral palsy, and so forth are a little more spectacular than the common cold, but I have often wondered, especially in view of the tremendous number of man-hours lost not only in the United States but all over the world due to colds, why more research emphasis has not been put on the common cold.

Dr. SEBRELL. If I may say a word there, it is an exceedingly difficult field of research. That was one of Dr. Topping's projects.

Mr. BUSBEY. That in itself ought to be a challenge to science.

Dr. SEBRELL. Well, you have to use human volunteers, and Dr. Topping did his work down here at the Lorton Reformatory and the Dis-

trict prison. And since you have no experimental animal and since the virus is exceedingly difficult to cultivate, it is very expensive and very difficult to do any research work with it. The way everybody has them, you would not think it would be a difficult research problem, but it is. But we recognize the terrific economic loss.

Mr. BUSBEY. It seems to me that there would be plenty of volunteers.

Dr. SHANNON. One of the difficulties with this disease called the common cold is its very infectiousness.

(Discussion off the record.)

Mr. BUSBEY. I think we ought to have a little more information on the record concerning some of the problems you run into at this reformatory.

Dr. SEBRELL. We will furnish that for the record.

(The information referred to follows:)

The problems and difficulties attending research in the common cold—both in terms of the Lorton study and in general—include the following:

First, it is very difficult to be certain that any given illness is actually an instance of the common cold. In its early stages certainly, this affliction resembles many other infectious diseases such as influenza, early whooping cough, or measles and the like. This means that it is not easy to select the patients to be used as a starting point for a study of the common cold.

Second, there are no laboratory animals susceptible to this disease so far as we have been able to determine. If one is to produce the disease at all, one must use human volunteers or, as an impracticable alternative, one can occasionally use the chimpanzee.

Third, during the season of the year when the common cold is prevalent and material is therefore available for study, it is necessary to take elaborate precautions that the volunteers to be inoculated are not exposed to infection in the natural way.

Fourth, since diagnosis of the disease is difficult and must depend upon clinical impressions rather than easily repeatable laboratory tests, there is usually disagreement among competent observers as to whether a given volunteer or a group of volunteers actually has the common cold at a particular time in the study.

Finally, there is a considerable question among many workers as to whether the common cold is really a single disease or is simply a convenient term applicable to a number of diseases which may have different causes. Even if one could assume that these various diseases were all due to related viruses, the problem would still be complex because it would be necessary to identify each of the viruses separately.

These difficulties indicate only briefly the nature of the basic problems which make it hard to attain progress in research on the common cold comparable with that in the other infectious diseases.

REVIEW AND APPROVAL OF RESEARCH AND TRAINING GRANTS

Mr. BUSBEY. All of your direct operations under this appropriation are concerned with the review and approval of research and training grants, except for activities which are on a reimbursable basis. Is that right?

Dr. SEBRELL. Yes, sir.

Mr. BUSBEY. Tell us something about what these 107 people do with regard to this review.

Dr. SEBRELL. I would like to ask Dr. Van Slyke to answer that, because it is in this research and training grant field that these are the individuals who handle the mechanism of taking care of research grant applications and so forth.

Dr. VAN SLYKE. Mr. Chairman, these 107 people are responsible for the receipt of every research grant application which we receive or every research fellowship application we receive and for training applications. These applications must be duplicated and supplied to the appropriate scientific advisers on our various studies sections and the Council which will get them finally. Besides that, this group of people supplies the scientific executive secretariatship of each of those study sections, so that you have a unification and melding of experience within the Division of Research Grants. Besides that, these people supply the stenographic assistance that is necessary; they also supply the auditing staff. All of our grants are audited from one central place, and this supplies the auditing staff for it.

I specifically call your attention to the fact that the $556,000 which is in the estimate is about the same figure that has been there now for the last 2 or 3 years. Although the grant funds have gone up and the load has become tremendously heavier, by economies of operation, by skill in the program, we have been able up to the present time to keep abreast of the flood of work which falls upon this particular group.

Mr. BUSBEY. Are these people in addition to those in the study sections?

Dr. VAN SLYKE. They are; yes sir.

TOTAL PERSONNEL TIME SPENT REVIEWING GRANTS

Mr. BUSBEY. How many man-years are spent in reviewing research grants, including all the people on the regular payroll of this appropriation and the various National Institutes, members of advisory groups, members of the study sections, and the personnel in the Surgeon General's Office?

Dr. SEBRELL. I would like to furnish that for the record. I do not believe we have that in our material here today, but I would be glad to get that up for you.

(The information is as follows:)

Man-years involved in review and approval of research and training grants, 1954 budget

Activity	PHS full-time staff	Advisory councils	Study sections	Total man-years
National Institutes of Health	98.8	0.2	3.5	102.5
Cancer	14.0	2.0		16.0
Mental	15.0	2.0	1.0	18.0
Heart	13.0	2.0		16.0
Dental	1.0	1.0		2.0
Arthritis	1.0	.2		1.2
Microbiology	2.0			2.0
Neurology	1.8	.2		2.0
Total	146.6	8.6	4.5	159.7

Mr. BUSBEY. What is the total cost of this review and approval, including both personnel and service costs and related costs, such as travel, supplies, and materials, and so forth? Will you furnish that for the record?

Dr. SEBRELL. Yes, sir; we will.

(The information requested follows:)

Total cost involved in review and approval of research and training grants, 1954 budget

Activity	Direct			Study sections	Total cost
	PHS full-time staff	Advisory councils	Total direct		
National Institutes of Health	$548,000	$8,000	$556,000	$115,000	$671,000
Cancer	79,700	20,300	100,000		100,000
Mental	105,700	24,300	130,000	18,000	148,000
Heart	67,500	22,500	90,000		90,000
Dental	4,360	6,640	11,000		11,000
Arthritis	11,500	6,500	18,000		18,000
Microbiology	15,000		15,000		15,000
Neurology	14,300	7,700	22,000		22,000
Total	846,060	95,940	942,000	133,000	1,075,000

PAYMENT OF STUDY SECTIONS AND ADVISORY GROUPS

Mr. BUSBEY. Are the various advisory group expenses paid out of grant funds or operating expense funds?

Dr. VAN SLYKE. The study sections, our scientific advisory panel, are paid out of grant funds. This is the procedure that has been reported to the Bureau of the Budget, and apparently they have no objection to it. It has the advantage of expediting the processing of vouchers; it keeps the thing under a central control; it permits the calling of ad hoc conferences through the chairman's grant so that things can be handled very expeditiously. And in terms of economy to the Government, it is economy, because you do not have to process these pieces of paper through regular channels. They are processed through this chairman's grant and research central committee. So we think we save a very large sum of money for the Government by this economical method of procedure.

Mr. BUSBEY. Then both the advisory groups and the study sections are paid out of grants?

Dr. VAN SLYKE. No. It is just the study sections.

Mr. BUSBEY. How about the advisory groups; how are they paid?

Dr. VAN SLYKE. The advisory groups are paid out of the review and approval item, which are direct funds.

Mr. BUSBEY. I cannot understand why they are not paid out of one fund, because they have similar responsibilities, do they not?

Dr. VAN SLYKE. Yes. I rather hesitate to put this on the record, but many of our scientific advisers, although they are leaders in the scientific fields in their area of scientific endeavor in this country, are hard pressed to dig up a couple hundred dollars for train fare and an additional $50 for hotel and living expenses, and then have to sit back and wait a month and a half for Government reimbursement. They like to get their checks within a few days, and by this method we can do it. And from their level of income, it is an extremely important consideration.

Mr. BUSBEY. Both in reality are operating expenses.

Dr. VAN SLYKE. Yes, sir. There is no difference. The members of the council are older people and have more financial stability and can better handle the delay which is inherent in processing expense vouchers.

Dr. SEBRELL. There is a little difference in them. The councils are statutory, you know, set up in the law, and they are concerned with policy and with administration. Whereas the councils are 6 laymen and 6 professional people, the study sections are completely professional people and give us only scientific judgment. They look at a project purely from the scientific standpoint—is it a good experiment? So there is a difference of function. The study section serves as a scientific body for the council, because the council is completely unable to pass on the scientific merits of these projects. As I say, it has 6 laymen and 6 professional people. They have a big stack of applications like this [indicating] that the study section gives a scientific review from the technical standpoint. The council is much better able to carry out those functions of advising. It could not do it without those technical features, and the study section is in essence making a contribution to science. At the same time, they themselves are getting a broad look at the whole field of research in which they are advising, and there is a different connotation between the council and the study section.

Dr. VAN SLYKE. I would like to comment further that the study sections advise all of the advisory councils. One study section can advise seven councils.

Dr. SEBRELL. We have one study section, say, on biochemistry. Any project in biochemistry going to any of the seven councils would pass through that advisory group for the biochemistry aspects of the project.

RESEARCH FELLOWSHIPS

Mr. BUSBEY. When Dr. Scheele was before the committee, he spoke very briefly regarding the fellowship program. I wonder if someone would give us a little more detail on that phase of the program. I notice that under this appropriation you are asking for funds, on page 98 of the justifications, for postdoctoral and special fellowships.

Dr. SEBRELL. You notice that is reduced by $75,000 under the research fellowships. That is occasioned by the taking over of the predoctoral fellows by the National Science Foundation, and we are going out of the predoctoral fellowship business and hereafter our research fellowships will be confined to postdoctoral fellows. And we will have in 1954 the reduced funds for awarding approximately 31 fellowships and will continue a few of the predoctorals we have already granted in order to complete them; but there will be no new predoctorals granted by us from now on. And these are the doctors of medicine, the doctors of physiology, who become competent research scientists in fields other than those that fall under the various categorical institutes.

Mr. BUSBEY. In the future, then, the National Science Foundation will take over all of the predoctoral fellowships that will be granted?

Dr. SEBRELL. That is right.

SPECIAL FELLOWSHIPS

Mr. BUSBEY. What about those special fellowships; what are they?

Dr. SEBRELL. They are a few instances where there are special reasons for an individual wishing to get highly specialized training. He may be well trained or nationally recognized in some field, but there is some sort of special project or activity in which further training is highly desirable.

Perhaps you could mention a specific instance or two, Dr. Van Slyke.

Dr. VAN SLYKE. I think we might point out that we had one of the leading endocrinological research men in the world take one of those special fellowships, and then we had the advantage of his advice, his counsel, and work in the stimulation of training, whereas we could not have done it because of civil-service rules. This also was at the time when we had Otto Warburg, who is the expert on cellular respiration. We made him a special fellow.

It gives us a chance to take opportunity by the forelock and bring in these leading scientists to work with us for short periods of time, up to a year.

Dr. SEBRELL. For a little time, we had three Nobel prize winners with us out at Bethesda for a period of some months, showing some of our people special techniques and teaching them and working with them, one of them in photosynthesis. We had men doing work on photosynthesis. You know how important that is in the plant formation of starch from light and carbon dioxide, one of the most economical reactions in the world and one which, if solved, would revolutionize the whole world's food supply. These Nobel prize men came and worked with us for a time and then went back.

BASES FOR DETERMINING ELIGIBILITY

Mr. BUSBEY. How is eligibility for a fellowship determined?

Dr. VAN SLYKE. You are speaking about the regular fellowship program, not the special?

Mr. BUSBEY. Yes; the regular fellowship program.

Dr. VAN SLYKE. That is established by certain stated criteria which we have published in the Federal Register. He must have a certain number of years' schooling, must have certain types of training which are required; he must be within certain age limits, and he must be a citizen of this country.

Mr. BUSBEY. Are they granted only if it is definitely shown that the applicant would not otherwise continue in the particular field of research?

Dr. VAN SLYKE. The application form which the applicant fills out has a statement to that effect and that he requires funds to continue his training which he would not continue unless he was granted a fellowship by us.

One of the most difficult chores we have is to select from huge numbers of applications just those few we have the money to pay for. That permits us to pick off the cream of the cream of the crop.

Mr. BUSBEY. Is there any agreement on the part of the individual that he will continue in the field for a certain number of years if the fellowship is granted?

Dr. VAN SLYKE. There is no formal requirement, but practically, if a man is willing to put in several years of his life on a special item, we have not much doubt he will take advantage of that special training, because he is being trained for this type of research work.

Mr. BUSBEY. Your experience, generally speaking, is that they do continue?

Dr. VAN SLYKE. Yes, sir. We have analyzed that from the people who have gone before, and an extremely high percentage stick right

in the field for which they are trained. Some of them do other fields of work because of interests they have developed along the way, but even then we do not consider those a loss at all.

REVIEW AND ALLOCATION OF GRANTS FOR TEACHING OF MEDICAL SUBJECTS

Mr. BUSBEY. Grants are made under some of the institutes for teaching medical subjects; are they not?

Dr. SEBRELL. Yes, sir. In some of the institutes there is a teaching and training grant fund.

Mr. BUSBEY. How many schools receive such grants?

Dr. SEBRELL. We will have detailed information on that by each of the institute programs where they have that program within the institute. The Cancer Institute, the Mental Institute, and the Heart Institute are the only three institutes that have those programs, and I do not have the data with me this afternoon, but each of those institute directors will furnish you with the institute data on each school—how much it gets and the whole information.

Mr. BUSBEY. Without objection, it will be inserted in the record at this point.

(The information follows:)

Teaching grants programs, 1953

Type of institution	Mental		Cancer		Heart	
	Number of schools	Amount	Number of schools	Amount	Number of schools	Amount
4-year medical schools	40	$600,000	73	$1,825,000	72	$1,008,000
2-year medical schools			8	40,000	7	56,000
Dental schools			42	210,000		
Osteopathy schools			6	150,000	6	84,000
School of public health					1	12,000
Special grants					3	213,000
Graduate:						
Psychiatry	65	761,000				
Clinical psychology	48	400,000				
Psychiatric social work	31	385,000				
Psychiatric nursing	25	250,000				
Public health mental hygiene	6	45,000				
Total	215	2,441,000	129	2,225,000	89	1,373,000

Dr. DEARING. I might say that all medical schools and all dental schools of the country, I believe, receive some grants under this grant program for teaching special subjects.

Mr. BUSBEY. How are those schools selected?

Dr. VAN SLYKE. Those are approved schools which make application, and their application must be recommended by the appropriate national advisory council, or they cannot be given a grant.

Mr. BUSBEY. Is that all that is necessary for them to be given a grant for teaching?

Dr. VAN SLYKE. No. Their application must show, first, what they request in the amount of funds; secondly, what do they request the funds for; thirdly, what are the facilities they have for doing what they propose to do; fourthly, how do they propose to use the funds requested, if granted.

DETERMINATION OF AMOUNT OF GRANT

Mr. BUSBEY. Do you have any formula for determining the amount that is allotted to each particular school?

Dr. VAN SLYKE. We have. In the field of cancer, the top grant is $25,000 per school for a medical school, and in heart right now the top grant is $14,000. It represents in the case of heart the broadest distribution that can be made of the funds available.

In the field of mental health, that is a special thing, because there the training grants also include stipends for the people getting the training. In mental health only schools that are definitely found to be competent to carry out psychiatric and psychological training, who have adequate departments set up for this purpose, are given training grant or teaching grant funds. In that instance, there is quite a number of such schools participating.

Dr. SEBRELL. I may add, Mr. Chairman, that these grants are exceedingly important to the medical schools; and their departments of oncology, in which they teach cancer, I think without exception are dependent on these grants. I do not like to speak in too much detail about them without the Director of the Cancer Institute here, but I am sure that they have resulted in a very great improvement in teaching students about cancer and in covering the whole subject in the medical school; and I think in many medical schools with respect to these mental health grants that their departments of psychiatry would fall apart without these grants.

ACCOMPLISHMENTS OF PROGRAM

Mr. BUSBEY. Are there any definite things you can set forth which have been accomplished with these funds which would not otherwise have been accomplished?

Dr. VAN SLYKE. Mr. Chairman, I would like to answer that if I may because I do not think it is a question of assistance to the medical schools. These grants provide a better type of training for the student. That is the person we are interested in, because he is the one who is going to work upon the citizens later, and not the school per se. We are really not interested, except tangentially, in assisting medical schools. We are tremendously concerned about improving and integrating courses of training which medical students get. That is really the purpose of the whole thing.

I think, as Dr. Sebrell pointed out a few moments ago, in the field of mental health if these teaching grants were not supplied then there are departments of psychiatry which would absolutely fall by the wayside, and we would not turn out the people needed, desperately short as we are of psychiatrists now.

Mr. BUSBEY. In your opinion, then, if these funds were not appropriated for this purpose it would cause a considerable handicap in the teaching of these subjects in the schools?

Dr. VAN SLYKE. That is right, Mr. Chairman. I think I would phrase it probably a little stronger. The failure to support this type of program in the future would be a really disheartening backward step. These funds do not carry with them any degree of control or regimentation of schools that participate. The deans of the medical schools—and I have had a chance to talk to most of them—appreciate

the need for these grants to do the kind of training that they want the medical students of the future to have. I think they are extremely important, sir.

Mr. BUSBEY. In effect, then, it is a subsidy to the school?

Dr. VAN SLYKE. Well, sir; I suppose you could call it a subsidy. The ultimate thing, of course, as I have pointed out, Mr. Chairman, is the subsidy really to the medical students' training. The better doctor that leaves the school after his period of training is what we are really interested in.

Dr. SHANNON. You might be interested, Mr. Busbey, in a study conducted by the University of California some 2 years ago on the knowledge that the average medical student had prior to and subsequent to the initiation of the cancer teaching grants. It showed a tremendous increase in the ability of the students to absorb knowledge relative to cancer, if it is presented in a highly integrated way, as compared to presentation department by department throughout the school. We might ask Dr. Heller, (Director, Cancer Institute) to make that information available to you.

DIFFERENCE BETWEEN TRAINING STIPENDS AND TRAINING GRANTS

Mr. BUSBEY. I notice in the justifications for the different institutes the terms "training stipends" and "training grants." Would someone explain what these are and what the difference is between the two?

TRAINING STIPENDS

Dr. VAN SLYKE. Mr. Chairman, the term "training stipend" refers to the award which is given to the person who is selected to further his clinical training.

In other words, with the program of training stipends we take the cream of the crop of the young doctors, male or female, and we make them competent in these special areas, whether it be cancer, heart, mental health, neurological diseases, blindness, or arthritis. This, then, provides our country with an increased group of practitioners who are and will be the leaders in their field. When they come to a community they very definitely step up the quality of practice in that medical area in that community.

The teaching grants are the ones we have spoken about as grants to medical schools.

Mr. BUSBEY. Are the "training grants" and "teaching grants" one and the same?

TRAINING GRANTS

Dr. VAN SLYKE. No, sir; training grants are another thing which I would take up next. Training grants are found only in the Mental Health Institute. They are really a mixture of teaching grant and training stipend.

The funds which the Mental Health Institue has for this present year, $3,676,000, provide grants to the schools to their departments of psychiatry and also provide awards for some 700 people in training in the various aspects of psychiatric disciplines. That does not mean,

Mr. Chairman, that 700 psychiatrists are in training, but it does mean 700 in that field, because some of them may be psychoanalysts, some of them may be concerned with special training in the field of psychiatric nursing, psychiatric social work, and so forth. Dr. Felix (Director, Mental Health Institute) will speak more to that point when he has an opportunity to appear before the committee.

ELIGIBILITY FOR TRAINING STIPEND

Mr. BUSBEY. How is eligibility for a training stipend determined?

Dr. VAN SLYKE. In the field of mental health it is a little different from the other fields, because there the schools have the primary responsibility of picking out the best people they can for the limited number of places they have available.

On the other hand, training stipends in heart are picked out centrally by a central board which passes judgment on them.

As I noted before in my remarks to the committee, the funds available permit us to skim off the cream of the crop.

Mr. BUSBEY. How much do they average per trainee?

Dr. VAN SLYKE. About $3,450, Mr. Chairman.

ACCOMPLISHMENTS

Mr. BUSBEY. What definite accomplishments have resulted which would not have come about in the absence of these stipends?

Dr. VAN SLYKE. Well, Mr. Chairman, since these stipends are aimed, in the field of training, at the production of clinically competent people I do not think we can point specifically to any accomplishments of these people. The program has not run very long. They are not well established, as it were, in their mature years. But a large number of these folks go into teaching, so that not only will they be competent practitioners of their speciality, but they are in a position to transfer their knowledge to the oncoming generations of medical students.

On the other hand, the training stipends in psychiatry probably are felt more immediately, because of the extreme shortage of competent people in the psychiatric field, so those people go to work right away.

GRANTS TO STATES FOR DETECTION, DIAGNOSIS AND OTHER CONTROL SERVICES

Mr. BUSBEY. Tell the committee what is covered by the term "Grants for detection, diagnosis, and other control services."

Mr. HARLOW. That is a State-grant item, Mr. Chairman, similar to what we have in tuberculosis and venereal diseases, made on the formula basis generally.

Mr. BUSBEY. What agencies or groups are eligible to receive these grants?

Mr. HARLOW. The States, State health departments.

Mr. BUSBEY. Who determines the eligibility and on what basis?

Mr. HARLOW. It is on a formula basis, Mr. Chairman, the same as the State-grant items we have in the other categories. Every State gets a portion of these funds.

STATE SUPPORT OF PROGRAM

Mr. BUSBEY. Why are not the State and local governments, and private organizations, able to finance these projects?

Dr. SEBRELL. You are referring to the research projects?

Mr. BUSBEY. Grants.

Dr. SEBRELL. Under the State grants?

Mr. BUSBEY. Yes. We are talking about this item, "Grants for detection, diagnosis, and other control services." Mr. Harlow has told us they are State grants.

Mr. HARLOW. I think we have discussed that previously in the hearings, Mr. Chairman, to the point where perhaps all of the reasons for these grants have been covered. I do not know that we could add anything particularly to the things that have been said.

With respect to some of these that appear here in the National Institutes of Health, I think we can take credit for stimulating and initiating very many worthwhile programs in the States that would not have been started had it not been for these funds. I will leave it to these other gentlemen to elaborate on that if it needs any elaboration.

Mr. BUSBEY. After these programs are started I do not understand why the States are not able and willing to take them over. In a lot of these Federal grants-to-States programs I am convinced that after this help has been given the States they ought to assume the financial responsibility if the projects are worth the money being spent on them.

It is always interesting to me to explore the reasons why this is not done, and what has been done to encourage the States to carry them on rather than looking to the Federal Government.

DEMONSTRATION PROGRAM

Mr. HARLOW. Well, it is in our demonstration program, Mr. Chairman, that we aim specifically at the thing you are mentioning. That is, if we find a worthwhile method of doing business sometimes the best way to get the States to pick that up is to get together a group of people who are quite competent in this particular field and send them out into the States and communities to show how these things can be done. After we have demonstrated we quite often succeed in having those practices incorporated into either State or local health organizations.

Mr. BUDGE. Why do you have to go further than that? Why should you finance the program once you have set it up? Why not let the State finance it?

Mr. HARLOW. Well, of course, you speak of Federal financing. What we as the Public Health Service are interested in, it seems to me, is getting a dollar's worth of health work for a Federal dollar, whether it goes to the State in the form of a grant or whether it be done by Federal personnel. We think perhaps it is a wise thing to leave the responsibility for most of these things in the hands of the State people, the State health people, and if they are unable to persuade their legislatures to appropriate money for these things we feel that nevertheless the health of this country is benefited to the extent that the Federal Government invests money in these things.

Mr. BUDGE. I think the State legislature might know the local needs perhaps better than the Congress of the United States and the executive branch of the Government in Washington.

Dr. VAN SLYKE. Mr. Chairman, may I offer a couple of comments for the committee's consideration?

No. 1: As to these State grants that are now supporting certain health activities, let us take, since it is not within our particular field in this group today, venereal diseases and tuberculosis. It would be of disservice to the people of this country if a State fell down on venereal-disease-control programs or tuberculosis-control programs and these infections became rampant in the State, because the interstate traffic is such that you cannot protect yourself merely by protecting within your own Sate. It must be a national effort.

On the other hand, I assure you I am not in conflict with what the members of this committee have said about "Can the States not take it over?" I think from what I read in the daily papers it is the President's concern that there might be some greater State participation in support of these health activities, but I think the President pointed out, if I read the papers correctly, Mr. Chairman, that the taxing area is the first thing to be resolved. If there be a redistribution of the taxing area, then the States probably would be in a position to take this over.

On the other hand, a too rapid dissolution of this program with biennial meetings of the State legislatures would create a tremendous health problem in this country.

Mr. BUDGE. But we have to take the step of reducing the Federal budget before we can give to States the broader field of taxation. It is like which came first, the chicken or the egg?

Dr. VAN SLYKE. Mr. Chairman, I would only comment that if there be a target date, then there can be a double shift at that time. Right now it would seem to be a disservice to the health of our citizens.

Mr. BUSBEY. So long as you are speaking about taxes, I think it is pretty well agreed that, from a tax standpoint and a financial standpoint, the States are in a much better position to handle the expense of these programs than is the Federal Government, inasmuch as we are fast approaching that $275 billion national debt limit.

If the material in the record does not cover the field adequately, please prepare any additional statements you feel are necessary and, without objection, we will have them inserted in the record at the appropriate places.

Dr. SEBRELL. We would be glad to do that, Mr. Chairman. We will have each of the institute directors concerned speak specifically for his own program if you would like the details.

(The following statement was subsequently submitted to the subcommittee:)

OBJECTIVES OF AND NEEDS FOR FEDERAL HEALTH GRANT-IN-AID PROGRAMS

The Federal Government has become an active partner with States in programs designed to deal with proposals which can no longer be confined to the boundaries of individual States. The entire Nation is interdependent in its reliance on the health and productive capacity of all its people. As a consequence, the health of residents in one State is of interest and concern to all other States. In addition, strong State and local health departments constitute the essential foundation for defense-related public-health activities.

In order to avoid duplication of function and activity with the States and communities and to maintain the essential advantages of local decision in planning and execution of prorgam, the Federal Government does not, however, provide direct public-health services to individuals. Rather, it makes its contribution in the form of assistance to States.

One essential form which this assistance takes is grants-in-aid. It is important to appreciate that financial assistance is only one aspect of the service, although it represents a very powerful lever against inertia. The Public Health Service does not exercise control in the narrow sense of being a supervising authority, but it constantly assists and encourages by educational or demonstrational methods the promotion of health by the State. It helps to conduct pilot programs and to show how a new method can be developed, and it provides special aid in widespread epidemics and disasters. The Public Health Service provides to an increasing extent expert advice of many kinds and programs of consultation. The Federal authorities have access to a mass of knowledge which it would be difficult for an individual State to discover on its own initiative.

Grants-in-aid for public health have three major purposes.

(1) Participation in the necessary financial support of basic State and local public health services.

(2) Help to equalize financial ability as between high- and low-income States, to provide necessary public-health services in the States and localities.

(3) The stimulation and demonstration of public-health programs in the States and localities when, through research and other scientific investigations, more effective methods become available for use in combating major national public-health problems.

Necessary financial support for basic State and local public-health services

In fiscal year 1951, the last year for which complete figures are available, Federal grant funds for public-health programs, excluding hospital construction, constituted 21.7 percent of the total public-health expenditures in the States.

It is important to note, however, that only 13 out of the 53 participating States and Territories have been able to maintain health services without a higher percentage rate of Federal participation than the national average of 21.7 percent. In 31 States and Territories the Federal share is above 30 percent, and in 16 States and Territories it is above 40 percent. The end effect of reduced Federal support in these States would be a reduction of already inadequate public-health services and a reversal of progress toward utilization of new techniques. In considering the overall financing of State and local public-health services, the following factors should be considered:

(*a*) The possibilities for improving the health of the people are rapidly increasing as research and other scientific investigations open up new avenues for public-health preventive and control services.

(*b*) The bulk of the increased expenditures for public health in recent years is concentrated in only a few States. Sixteen States account for 89 percent of the increase in State appropriations over the past 10 years, as adjusted for increased costs of providing services since 1942.

(*c*) Large numbers of people in this country still have available to them only fragmentary and inadequate public-health services. Approximately 40 million of the Nation's population are living in areas not served by organized local health departments. Of the 1,706 counties and cities served by local health departments, only 34 counties and 3 cities meet the minimum staffing standards for all 4 classes of basic personnel; only 69 counties and 27 cities have an adequate number of nurses; only 632 jurisdictions have adequate sanitation personnel and 871 an adequate number of physicians. These standards have been developed over a period of years after considerable study by official and nonofficial health agencies and represent pooled professional judgment.

These facts show that the majority of the States have not progressed to a point where a decrease in Federal grants could be made without seriously impairing both their current health programs and their opportunities to improve the quality and coverage of services. Even to maintain services at the present level without Federal financial assistance, 5 States would need to double the State and local funds they now spend for public health, 9 States would have to increase their funds 75 to 100 percent, and 17 more would have to increase their funds 50 to 75 percent.

Equalization of financial ability among States to provide necessary public health services

There is a variation of 2½ times in the per capita income between States of the highest and lowest income. Many public-health problems are more severe in the lower income States.

The Public Health Service grants-in-aid tend to equalize the fiscal ability of States to provide basic public-health services by making available larger per capita grants to the low-income States. Notwithstanding this fact, available data indicate that in general these low-income States spend a larger proportion of their own financial resources for public-health purposes than do States with greater financial resources. The States of Georgia, Mississippi, North Carolina, and Louisiana in per capita income rank 42, 49, 45, and 41, respectively. These same States rank 4, 6, 8, and 9 in the proportion of their own financial resources spent for public-health services. Therefore, curtailment of Federal grants-in-aid for public health would more seriously affect those States which are least able financially to make up such a deficit in Federal funds. These States are putting forth the greatest financial effort in public health in relation to their financial capabilities.

Stimulation of needed new services

Grants-in-aid have stimulated the inauguration of many services in the States and localities in such programs as venereal-disease control, tuberculosis control, cancer control, heart-disease control, mental-health activities, which did not exist before Federal grants were made available for these purposes. In these cases Federal grants have provided the means by which a nationwide effort could be conducted to meet public-health problems considered by the Congress to be of urgent national interest.

A substantial amount of research is being conducted on various public-health problems, particularly those of the chronic diseases. As research develops the knowledge of how to prevent and control disease, it is in the public interest to have this knowledge translated into effective control and preventive measures, many of which will require extension of public-health services in States and localities. The grant-in-aid method, including the consultative services provided with it, has proved to be a practicable and effective means for translating public-health knowledge into public-health action on a national scale.

Mr. FERNANDEZ. May I also repeat my observation that some States are better able than the Federal Government to foot these bills because the people from other States, in the purchase of the goods which these States manufacture, help to pay the taxes collected by industrial and manufacturing States.

And may I make the additional observation right here that it is the Federal Government which is interested in having healthy soldiers?

Mr. BUSBEY. Mr. Fernandez has a very peculiar problem in New Mexico, I might state, because the Federal Government has taken most of the land of his State. What percentage of New Mexico does it now own?

Mr. FERNANDEZ. We are not as bad off as Arizona and Nevada. The Federal Government owns 40 percent of our State. I think it owns about 70 percent of Nevada.

Mr. BUDGE. You are better off than the State of Idaho. We only own one-third of the State and the Federal Government owns two-thirds of it.

GRANTS FOR CONSTRUCTION OF RESEARCH FACILITIES

Mr. BUSBEY. I notice that you have several million dollars included in grants for construction of research facilities. Will you tell the committee briefly how these grants will be made.

Mr. STEPHENS. Mr. Chairman, may I interject this: That item, the whole $15 million, has been withdrawn in the agency's recommendations to the Bureau of the Budget; and, so far as I know, they have been accepted, for the withdrawal of the item. I do not mean to infer that the doctors here will not tell you what it was for, but it has been withdrawn.

Dr. SEBRELL. I would be glad to speak to it if you would like, Mr. Chairman.

Mr. BUSBEY. If you care to, briefly.

Dr. SEBRELL. The money was for the construction of research facilities in various universities and hospitals and medical schools throughout the country. These were not Federal facilities, but research facilities back in the States, because many of the universities find themselves now in a position where they wish to do research, but they are unable to provide the space and the facilities in which to do it. This was an effort to meet in a very small way some of this tremendous backlog of demand.

We have had indications that the need as expressed by responsible people writing to us, runs into many, many millions of dollars that could be profitably invested in research facilities which would be used not by the Federal Government at all, but by the people back home to further the developments within their own institutions.

Mr. BUSBEY. Had you asked the Bureau of the Budget for funds for research facilities?

Dr. SEBRELL. It was in the Truman budget, the one that is here.

Mr. BUSBEY. That does not quite answer my question.

Dr. SEBRELL. I believe that item, sir, was added late in the budget process to the total budget. I do not quite know the mechanism concerned.

Mr. BUSBEY. Well, it was not an item which was included in the budget by the National Institutes of Health?

Dr. SEBRELL. In the original submission; no, sir, but I would call your attention to the fact that we had such sums 2 or 3 years ago which were cut off. It was our feeling that such sums of money for this purpose would be desirable if it fitted within the economy to provide it. So although we did not ask for it in the original submission it was, nevertheless, a need which we recognized.

1954 BUDGET OF NATIONAL INSTITUTES BY FUNCTIONAL CATEGORY

Mr. BUSBEY. Dr. Sebrell, I think it would be very helpful to the committee and the House if you would prepare for the record a statement showing the total requests of the National Institutes of Health, broken down by appropriation item and by category; that is, direct appropriations and each of the grant categories, such as research grants, teaching grants, construction grants, and so forth.

Dr. SEBRELL. Yes, sir; I would be glad to.

Mr. BUSBEY. If you will prepare that for the record it will be entered at this point without objection.

(The information is as follows:)

	Operating expenses, NIH	Arthritis	Micro-biology	Neurology	Cancer	Mental	Heart	Dental	Total
Grants:									
Research projects	$4, 500, 000	$2, 614, 000	$2, 947, 000	$4, 328, 000	$4, 734, 000	$2, 665, 000	$5, 070, 000	$564, 000	$27, 422, 000
Research fellowships	124, 000	135, 000	117, 000	150, 000	514, 000	187, 000	357, 000	50, 000	1, 634, 000
Teaching grants					2, 225, 000		1, 373, 000		3, 598, 000
Training grants				210, 000		4, 176, 000			4, 386, 000
Training stipends		150, 000		100, 000	500, 000		250, 000		1, 000, 000
Grants to States					3, 000, 000	3, 100, 000	1, 500, 000		7, 600, 000
Special control grants					900, 000				900, 000
Construction grants		2, 000, 000		2, 000, 000	4, 000, 000	2, 500, 000	4, 000, 000	500, 000	15, 000, 000
Total grants	4, 624, 000	4, 899, 000	3, 064, 000	6, 788, 000	15, 873, 000	12, 628, 000	12, 550, 000	1, 114, 000	61, 540, 000
Direct operations:									
Research		3, 346, 000	3, 718, 000	797, 000	5, 277, 000	1, 990, 000	3, 322, 000	579, 000	19, 029, 000
Review and approval of grants	556, 000	18, 000	15, 000	22, 000	100, 000	130, 000	90, 000	11, 000	942, 000
Training activities						70, 000			70, 000
Technical assistance to States					400, 000	398, 000	345, 000	800, 000	1, 943, 000
Coordination and development of dental resources									
Administration		187, 000	203, 000	63, 000	350, 000	284, 000	193, 000	126, 000	126, 000
Total direct operations	556, 000	3, 551, 000	3, 936, 000	882, 000	6, 127, 000	2, 872, 000	3, 950, 000	70, 000	1, 350, 000
Appropriation estimate	5, 180, 000	8, 450, 000	7, 000, 000	7, 670, 000	22, 000, 000	15, 500, 000	16, 500, 000	1, 586, 000	23, 460, 000
								2, 700, 000	85, 000, 000

DISTRIBUTION OF CLINICAL CENTER COSTS

Mr. BUSBEY. Returning to the subject of the new clinical center, for just a moment, how is the exact amount of reimbursement from each of the individual institutes going to be figured when you get into operation?

Dr. SEBRELL. That will be figured partly on the basis of the prorated share of the material and space and services they use. It cannot all be individually cost-accounted, because if we try to do that, for example, our opening the clinical center with 1 nursing unit and perhaps 15 cases of cancer, would throw the entire expense of the clinical center onto the Cancer Institute which certainly they could never stand, and it would not be fair anyhow. So we will try to distribute the total costs across the institutes by application of various criteria for estimating the use they make of centralized facilities.

I cannot answer that question in complete detail at this moment because, as I indicated originally, we are still guessing and we are going to have to try out various procedures with the best advice we can get both within and without the Government, to arrive at a fair allocation of these costs. It is proving to be exceedingly complex to break down our research work into research versus patient care costs and give full consideration to the various factors you have to include to come up with a fair answer. We are just going to try to do it as fairly as we can, taking into account all the factors concerned.

Mr. BUSBEY. Well, at best, it is going to be a complicated job to divide all of the cost of the utilities and other overhead items, as well as the more direct services such as food, nursing, and so forth.

Dr. SEBRELL. Well, it will be complicated but not impossible. We are getting the help of the General Accounting Office and we are getting the help of representatives of the American Hospital Association and we are trying to put in a businesslike method of operation that will reflect the best thinking of all of our advisers.

Dr. SHANNON. Could I give you some of the practices being used, Mr. Chairman?

Mr. BUSBEY. Please.

COST FORMULAS

Dr. SHANNON. In the patient-care area the cost allocated to each institute will be directly proportional to the activated beds budgeted during a given year. In the research-services area the cost is broken down into a series of items: "Administration and supply services," "Research plant and equipment services," "Laboratory research services," "Scientific report services," "Clinical center services," "Laboratory and patient areas." Each of those items has been calculated on a formula that we consider best suited for the specific item.

On the basis of that formula, the cost is prorated for a given institute. For example, for "Administration and supply services" the share of the cost for one institute is in direct ratio to the direct operating funds of the Institute, when compared with the total direct operating funds for all institutes.

In "Research plant and equipment services," each institute has these costs in direct ratio of institute personnel to total personnel of all institutes stationed at Bethesda.

Formulas of that general sort have been applied in these estimates, which are our best judgments. After a year's experience, this formula will be modified wherever indicated.

COST OF PATIENT CARE

Mr. BUSBEY. Have you figured out an estimated average cost per patient-day in the hospital?

Dr. SHANNON. No, sir; we can break it down in such a way as to give us any cost you want. One must realize that these patients are in a hospital for research purposes. Certain patient-care facilities will be furnished by the clinical center, but physician's care for the patient will be furnished by the Institute. Depending upon how much of the patient care is charged to the research and how much is charged to simple patient care, the cost of the patient-care item will vary widely.

We feel that such a breakdown is wholly arbitrary and unreal. It is not amenable to checking. So we have not attempted to break the figures down into research costs on the one hand and patient-care costs on the other.

Mr. BUSBEY. I appreciate the fact that there would be no fair comparison between the costs per patient per day at the clinical center and at an average hospital, but I was just wondering if you had an estimate of the cost on that basis for the center.

Dr. SHANNON. We will furnish you the rough breakdown.

(The information is as follows:)

Patient-day costs will vary depending upon the definition one uses to distinguish between (1) patient care, and (2) research related to patients. In addition, during the build-up period, costs per patient-day are affected by the method of charging for "lead time" of new personnel employed prior to opening new units. The cost is also affected by the method of allocating fixed and indirect costs in a facility only partially opened. Depending on how these factors are treated, the estimated cost per patient in 1954 will range from $50 to $80 per day.

Using one definition, which excludes physician care and indirect costs, the clinical center at full occupancy would provide patient care at approximately $46 per day.

Dr. SEBRELL. Anything we would give you now would be a guess, but we are going to so operate that after a year's experience we will be able to supply you with accurate information on anything we can foresee anyone will want to know.

Mr. STEPHENS. Mr. Chairman, in connection with this very complex accounting problem out there there have been two agencies of Government who have waded in on me half a dozen times about an elaborate bookkeeping system where every time they went over and got a white rat for cancer they would charge cancer up with that white rat. That is so obviously asinine you cannot run it that way. It has to be done on more or less of an annual basis.

You may be a taxpayer in Bethesda, and you may pay taxes to support the fire department and you may never use it. That is the way with the animals out there. There might not be a rat or a rabbit used in 30 days in leukemia, but they are preparing to charge the Institutes on the basis of availability of those things on an annual basis. It will take some experience to shake that down to where you can make an

absolutely equitable and fair charge to all of the Institutes based on the services they receive from all of these central services.

TOTAL COST OF OPERATING CLINICAL CENTER

Mr. BUSBEY. I think it would be helpful to the committee if we inserted in the record at this point pages 101 to 107, inclusive, of the justifications; and without objection they will be entered at this point.

(The documents are as follows:)

Clinical center services to laboratory and patient areas

	Estimate, 1953		Estimate, 1954		Change (+) or (−)	
	Positions	Amount	Positions	Amount	Positions	Amount
Personal services	792	$1,167,842	1,198	$3,203,000	+406	$2,035,158
Travel		25,500		46,000		+20,500
Transportation of things		4,800		10,000		+5,200
Communication services		41,000		52,300		+11,300
Rents and utility services		1,500		3,000		+1,500
Printing and reproduction		10,000		10,000		0
Other contractual services		10,000		10,000		0
Supplies and materials		259,600		548,600		+289,000
Equipment		19,500		9,500		−10,000
Taxes and assessments		3,100		7,700		+4,600
Deduct quarters and subsistence		−1,642		−85,600		−83,958
Total		1,541,200		3,814,500		+2,273,300
Less reimbursements		−1,541,200		−3,814,500		−2,273,300
Net obligations		0		0		0

General statement

This project provides funds for the progressive activation of a maximum of 300 beds in the clinical center during the fiscal year 1954. Present plans call for the activation of 150 beds by June 30, 1953.

The opening of the clinical center in the spring of 1953 will be a step forward in the field of medical research. As a research center of nationwide importance, it will afford extensive and exceptional opportunities for testing and demonstrating effective treatment methods on the diseases of man and for the acquisition of new knowledge of disease processes and factors which condition their progress. The end product of this clinical approach, as in all research, will be ideas; ideas that will be used to advance medical knowledge for the benefit of all mankind.

The arrival of the first patient in the clinical center at Bethesda in April of 1953 will bring together the patient, clinician, and laboratory research and thus bind together the chain of medical research. Extensive consideration has been given to the effective promotion of medical research and the necessity for the best possible patient care in planning the clinical center. One consideration complements the other, as clinical research must be geared to studies of groups of individual patients receiving the best of medical care. The patient will be, in reality, a member of the research team, and the length of his stay in the clinical center will vary with the requirements of such research.

The staff of the clinical center is presently being organized in such a manner as to carry out the research programs effectively. The interdependence of all organizational units is emphasized and the staff will indeed be a series of integrated research teams.

The funds necessary to operate the patient care facilities of the clinical center are secured from the seven institutes based on a formula of patient-days and the supporting research services involved. In preparing this budget, therefore, the primary consideration has been the plan for activating beds. It is planned that 150 beds will be activated by June 30, 1953; a gradual increase to 300 beds is proposed by June 30, 1954.

Personal services

The increase in personal services will be allocated as follows:

Increase necessary to carry the 1953 program of 150 activated beds to a full-year basis during 1954	$1,349,658
Increase necessary for an additional 150 beds to be activated during 1954 (406 new positions)	685,500
Total	2,035,158

The integrated laboratory and research programs will begin in the latter part of 1953. As of June 30, 1953, 792 employees will be on duty supporting 150 activated beds in the clinical center. To maintain this level of operation in 1954, there will be required 415 additional man-years at a net cost of $1,349,658. The expansion of the 1953 program will be principally in the patient-care areas. Provision is made for an adequate nutritional staff, nursing staff, professional and medical staff, and related supporting services.

The additional 406 positions necessary to place in operation an additional 150 beds during 1954 are for specific departments and functions within the clinical center organization, as follows:

The professional service staff, rendering service to all areas of investigation and medical patient care, will require an additional 66 positions in 1954. Additional surgeons, anesthetists, dentists, diagnostic X-ray specialists, and supporting technicians will be required, based on an increasing number of patients and expanded research facilities.

The social-service staff will be increased by 15 positions to more effectively handle a larger patient workload and expanded clinical research facilities. Information concerning the patient's social, economic, and environmental status is necessary in selecting patients for study in order that they may be retained until research is completed. In addition, it is proposed to add two positions to the staff following up on patients released by the clinical center but with whom contact must be maintained for completion of research study.

An additional 174 nurses and nursing aides will be required in 1954 to care for an increasing number of patients. In addition to patient care, specialized nursing services are provided for each institute conducting research in the clinical center, and for operating rooms, examination rooms, and other areas.

It is proposed that the nutrition staff, responsible for patient meals and the operation of an employee cafeteria, be increased by 37 employees. An increasing amount of raw food will be purchased, prepared, and served to patients and employees during 1954. (Increased funds for the employee cafeteria will be collected from sale of meals.)

An increase of 112 positions for housekeeping, laundry, operation of plant and equipment, maintenance of housing, and other supporting services will be required in 1954 as the clinical center expands to a 300-bed level.

Operating experience in 1954 may require some adjustments from the proposed increases between departments and functions to assure greater effectiveness in carrying out the overall programs.

Other objects

Travel, +$20,500.—The expanded research operation to be conducted in conjunction with the newly created clinical facilities at Bethesda makes necessary an increasing amount for transportation of patients to and from the clinical center, payment of expenses of consultants, costs of changes of official station, visits to hospitals and other institutions, and a minor amount for attendance at essential scientific meetings.

Transportation of things, +$5,200.—Provision is made for an increasing amount of freight and drayage charges for supplies and materials during a period of expanded operations.

Communication services, +$11,300.—As new clinical center areas are occupied and new staff is employed during 1954, additional funds will be required for telephone, telegraph, teletype, and other forms of communication.

Rents and utility services, +$1,500.—The increase is needed to supply additional amounts of electricity, gas, and water for the apartment house during 1954.

Supplies and materials, +$289,000.—(a) Purchases of food and dietetic supplies will be increased to serve additional meals to an increasing number of patients and employees during 1954. Employees will obtain meals in a modern cafeteria located in the clinical center, costs of which will be borne by the employees and reimbursed to the appropriation. (b) Additional purchases of drugs, chemicals,

and sterile supplies will be made to meet an accelerating patient workload and expanded research studies.

Equipment, —$10,000.—A reduction of $10,000 is reflected since the estimated value of purchases in 1953 required initially for the patient care area exceeds estimated comparable requirements for 1954.

Taxes and assessments, +$4,600.—The increase provides for the cost of the employer's contribution to the social-security fund for employees not covered by provisions of the Civil Service Retirement Act.

Research services

	Estimate, 1953		Estimate, 1954		Change (+) or (−)	
	Positions	Amount	Positions	Amount	Positions	Amount
Personal services	692	$2,021,400	705	$2,426,900	+13	+$405,500
Travel		1,600		1,600		0
Transportation of things		3,000		4,000		+1,000
Communication services		19,300		19,300		0
Rents and utility services		164,800		280,800		+116,000
Printing and reproduction		19,300		19,300		0
Other contractual services		56,200		45,000		−11,200
Supplies and materials		576,800		732,800		+156,000
Equipment		111,300		57,300		−54,000
Taxes and assessments		7,500		9,200		+1,700
Deduct quarters and subsistence		−1,200		−1,200		0
Total		2,980,000		3,595,000		+615,000
Less reimbursements		−2,980,000		−3,595,000		−615,000
Net obligations		0		0		0

General statement

This subactivity finances auxiliary research services for all institutes of the National Institutes of Health, including clinical-center operations. These services include production of special strains of experimental animals, construction of special equipment and precision instruments not available on the open market, provision of culture media, washing and sterilization of glassware, laboratory design and maintenance facilities, heat, steam and power, scientific photography and medical art facilities, supply and medical library facilities. Part of the clinical center and related buildings open late in 1953, and will be open for a full year in 1954. More units will open in 1954. Increased costs are due entirely to these two factors. These increases are partly offset by a transfer of certain supply services to another appropriation account.

Personal services

Full-year employment for positions new in 1953	+$405,300
Program expansion, 41 new positions	+86,700
Transfer of 28 employees engaged in central storeroom services to the service and supply fund	−86,500
Net increases	+405,500

The gradual opening of the clinical center will require:

(1) Ten more persons to wash and sterilize glassware and animal cages. Net cost, $19,700.

(2) Twenty-five new positions at a net cost of $50,000 will be needed in the mechanical engineering sections and the various craft shops as the wings of the main structure are opened.

(3) As clinical-center activities expand, increased purchasing of special items and essential property control functions will necessitate six new positions at a net cost of $17,000.

Other objects

Transportation of things, +$1,000.—This increase in shipping, freight, and drayage charges, primarily for shops and maintenance supplies, is required to provide a full year's operation of 1953 program expansion.

Rents and utility services, +$116,000.—This item covers increased electricity, water, and gas required in 1954 to service the clinical center and auxiliary buildings, which will be occupied for only a portion of 1953.

Other contractual services, —$11,200.—The availability of laundry facilities at the National Institutes of Health in 1954 makes it possible to terminate contracts for laundry service with resultant savings. An additional decrease is attributable to the transfer of central storeroom operations to another account.

Supplies and materials, +$156,000.—The principal item of increase is for additional fuel oil necessary to produce steam for heat, sterilization, and hot water in connection with full-year occupancy of the clinical center and auxiliary buildings in 1954. This increase in fuel-oil requirements is commensurate with the increase in space to be utilized.

Nominal increases are also provided in animal forage, fabricating supplies for shops engaged in constructing special-research laboratory items, gasoline and oil for increased use of ambulances and automotive equipment, and uniforms for added custodial personnel located in the clinical center. These increases are partially offset by a decrease of $3,000 due to the transfer of storeroom services to the service and supply fund.

Equipment, —$54,000.—The availability of new or modernized facilities in 1953, for operation of a number of the auxiliary, technical, and laboratory services carried under this activity, makes it possible to effect a temporary reduction in normally recurring equipment requirements in 1954.

Taxes and assessments, +$1,700.—The increase provides social-security tax for employees who are not covered by provisions of the Civil Service Retirement Act.

Administration

	Estimate, 1953		Estimate, 1954		Change (+) or (−)	
	Positions	Amount	Positions	Amount	Positions	Amount
Personal services	149	$629,904	164	$686,904	+15	+$57,000
Travel		8,200		8,200		0
Transportation of things		300		300		0
Communication services		10,500		10,500		0
Rents and utility services		12,000		21,000		+9,000
Printing and reproduction		7,000		7,000		0
Other contractual services		7,200		5,800		−1,400
Supplies and materials		21,000		23,000		+2,000
Equipment		7,500		7,500		0
Taxes and assessments		1,500		1,700		+200
Deduct quarters and subsistence		−4,104		−4,104		0
Total		701,000		767,800		+66,800
Less reimbursements		−701,000		−767,800		−66,800
Net obligations		0		0		0

General statement

Funds are provided under this activity for overall management direction and central management services for all Institutes and functions comprising the National Institutes of Health. Specifically, funds are provided for the Director, National Institutes of Health, and his immediate staff, financial management, office services, personnel, management analysis, and the Board of Civil Service Examiners. The additional funds requested in 1954 will be required for handling increased workload created by expanded clinical-research activities. This activity is completely financed through reimbursements from the several Institute appropriations.

Changes in reimbursable amounts reflected in each Institute's appropriation are due partly to the increase in 1954 for expanded clinical-center activities, and partly to changes in factors influencing amounts to be reimbursed by each Institute which resulted in offsetting increases and decreases, as between Institutes.

Personal services

An increase of $38,000 is required to finance for a full year positions new in 1953. In addition, 15 new positions at a net cost of $19,000, will be required in 1954 to provide adequate payroll, other accounting, and tabulating services for expanded programs incident to clinical-center utilization.

Other objects

Rents and utility services require an increase of $9,000 to finance, on a full-year basis, the rental of tabulating equipment delivered during 1953.

Other contractual services reflect a decrease of $1,400 in requirements for repair of office machines and equipment.

An increase of $2,000 is required for supplies and materials for accounting and tabulating services.

The estimate for taxes and assessments provides an increase of $200 to cover the costs of social-security tax payable on new positions not covered under the Civil Service Retirement Act.

Mr. BUSBEY. It is not clear to me from the justifications just how much the operation of the clinical center will cost. Does the table on page 101 show the total cost?

Dr. SHANNON. The table on page 101 shows the total cost of patient and laboratory services within Building 10, which is the physical structure known as the clinical center. In addition to that, it will carry the cost of laundry and such ancillary services as are provided within the clinical center for the running of the building as a central facility. This project does not include the costs of the Institute's own research teams.

Dr. SEBRELL. Let me point out in this connection that this amount of money given on page 101 provides for the progressive activation up to a maximum of 300 beds at the end of fiscal 1954, assuming we were going to enter 1954 with 150 beds. Since we now enter 1954 possibly with no beds, certainly that figure of 150 will necessarily be different. There will be some saving on it, in all probability, and it does not in any way represent the year's cost, of course, for running at the 300-bed level, because we will only reach 300 beds in June 1954, and then a full year at 300 beds will be an entirely different figure, of course.

Mr. BUSBEY. Is the estimate of $3,595,000 on page 104 also a part of the total clinical-center cost?

Dr. SHANNON. I was in error in my previous statement, in that I told you this figure on page 101 of $3,814,500 is the total cost of running Building 10. Our own breakdown of all the services necessary for operating all our new facilities, including the clinical-center building will run to a total cost of $4,645,600. (NOTE.—The total cost of the clinical-center program, including clinical investigations, visiting scientists, and administration, is $6,686,500, a net increase of $3,999,300 on the 1953 appropriations. Detail of the $6,686,500 is shown in chart A, below.) Of course, this figure is based on 150 beds beginning July 1 and going up to 300 by the following year. It is a little difficult to give you a breakdown of what that will likely mean in the coming year when we do not know when the facility is going to start.

We could give you that figure based on several alternative probable costs, making certain basic assumptions as of June 1, July 1, reaching so many beds, and so forth. If you would like us to give those alternative tables, we would be glad to supply them.

Mr. BUSBEY. Without objection, they will be entered in the record at this point.

(The information and tables are as follows:)

Estimate of clinical center costs in 1954 based on alternative plans for bed activation

	Starting date for patients	Beds by June 30, 1953	Maximum beds reached in 1954	Date maximum beds reached in 1954	Clinical center services to laboratory and patient areas	Research services	Administration	Clinical investigations	Total
1954 congressional budget request (for comparative purposes).	Apr. 1, 1953	150	300	May	$3,549,500	$1,096,100	$126,700	$1,914,200	$6,686,500
Alternative plans for 1954:									
1	July 1, 1953	0	250	do	2,900,000	959,000	126,700	1,724,500	5,710,200
2	June 1, 1953	45	300	do	3,320,000	1,096,100	126,700	1,914,200	6,457,000
3	July 1, 1953	0	300	do	3,200,000	1,096,100	126,700	1,914,200	6,337,000

CHART A

Distribution of costs attributable to clinical center included in total 1954 budget

	Arthritis		Microbiology		Neurology		Cancer		Mental		Heart		Dental Institute		Total	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
FISCAL YEAR 1954																
Research:																
Clinical investigations	53	$302,200	32	$180,000	36	$204,000	61	$425,800	41	$263,000	63	$306,200	18	$136,400	304	$1,817,600
Visiting scientist		8,000				10,000		34,000		17,200		6,000		21,400		96,600
Subtotal	53	310,200	32	180,000	36	214,000	61	459,800	41	280,200	63	312,200	18	157,800	304	1,914,200
Clinical Center services to laboratory and patient areas		520,200		515,500		321,700		888,900		614,900		666,500		21,800	1,198	[1] 3,549,500
Research services		214,600		197,200		39,600		310,400		112,900		187,400		34,000	221	[2] 1,096,100
Subtotal		734,800		712,700		361,300		1,199,300		727,800		853,900		55,800	1,419	4,645,600
Total research		1,045,000		892,700		575,300		1,659,100		1,008,000		1,166,100		213,600	1,723	6,559,800
Administration		20,600		24,500		3,800		37,200		15,200		20,700		4,700	37	[3] 126,700
Total		1,065,600		917,200		579,100		1,696,300		1,023,200		1,186,800		218,300	1,760	6,686,500

[1] Reflects net appropriation request, therefore excludes reimbursements of $265,000 for sale of employee meals. The $3,549,500 shown above plus the $265,000 will add to the $3,814,500 shown in the obligation schedule on p. 101 of the congressional budget submission.
[2] Indicates share of the $3,595,000 for research services shown on p. 104 that is attributable to the expanded Clinical Center operation.
[3] Indicates share of the $767,800 for administration shown on p. 106 that is due to the expanded Clinical Center operation.

RESEARCH SERVICES

Mr. BUSBEY. How about the $3,595,000 on page 104 for research services?

Dr. SEBRELL. That in no way duplicates money given on page 101. This is money for services to research activities through the NIH, including research in the existing laboratories as well as research in the new clinical center—not just for the patient services in the clinical center. The figures on page 101 are the other services provided by our clinical center organization to the patient areas and the laboratories in that building.

ADMINISTRATION

Mr. BUSBEY. Then you have the reimbursable item, "Administration," shown on page 106. Just what does it cover?

Dr. SEBRELL. You refer to the $767,800?

Mr. BUSBEY. Yes.

Dr. SEBRELL. That $767,800 is the salary for the immediate staff of the Director of the NIH, the Board of Civil Service Examiners, financial management, personnel administration, and such other activities as are essential to manage the National Institutes of Health as a whole. Those funds are reimbursed by the institutes in proportion to the size of their direct operations.

FIELD STAFF AND RELOCATION OF PROJECTS

Mr. BUSBEY. In how many different locations in the United States do you now have National Institutes of Health personnel assigned?

Dr. SEBRELL. There are many different locations under the different institutes. I cannot give you the exact number offhand.

Mr. BUSBEY. Could you submit a list for the record with just a sentence or two telling the purpose of each and indicating which ones will be discontinued when the clinical center is in full operation?

Dr. SEBRELL. I will be glad to do that. The total number of stations is 40 with about 400 to 500 total personnel, roughly, and many of those are temporary installations that will be moved into the clinical center when the proper time arrives. Some of them are field stations which have been there a long time and are fairly considerable stations and which we would continue to operate for special research, such as the laboratory in Montana and some others. But we will furnish a list for the record. (Information regarding field stations unaffected by project relocation program may be found on page 989, et seq.)

Dr. SHANNON. This may cause some embarrassment during the summer, because covered in the 1953 budget are funds for relocation of projects. In the absence of completion of the clinical center to move those stations in, and with the delay in the completion of the laboratory areas, we may find ourselves involved in serious financial difficulty in moving them later.

Dr. SEBRELL. Our money to move them is in the 1953 budget. If we cannot get them moved by July 1 and have to move them in the next fiscal year, we are going to be in some financial trouble. We will move them if we can possibly do it.

ENTERTAINMENT OF VISITING SCIENTISTS

Mr. BUSBEY. I notice in the appropriation language on page 152 of the committee print that you have had, and wish to have continued, the authority to spend $1,000 for entertaining visiting scientists. Why do you need that money, and how much was spent in 1952?

Dr. SEBRELL. We need that, Mr. Chairman, because NIH has an international reputation. We have a constant stream of visitors of many hundreds from all parts of the world. Many of them are outstanding scientists, and many of them are prominent people in their own governments, such as directors of health or heads of research departments or various things of that kind. It had become quite a financial burden on the staff there in entertaining these people. Many of them come in the middle of the day when the only thing we can do is to take them to lunch. They are a long way from home, and they expect the normal courtesies they give our people when they visit their countries or their research centers. It had become quite a financial drain on the people concerned, which was not fair. Specifically in 1952 we spent $882.98 of that $1,000. To date this year we have spent, so far, $233.98. The springtime is the time we have the heavy load of foreign visitors—the spring and early summer. Between now and the 1st of July we will probably spend the largest amount of that if we are permitted to do so.

Mr. BUSBEY. I think that within reason they should be given proper courtesies. What, specifically, are the things for which it is spent?

Dr. SEBRELL. Most of it is spent for luncheons or for dinners at which an individual is entertained with scientific or professional colleagues from around Washington—people from the Naval Medical Research Center, people from Walter Reed, people from the Department of Agriculture, the National Science Foundation. There will be some small entertainment, either lunch or dinner, at which not infrequently the individual gives a little speech or he has a chance to chat with his colleagues about professional matters.

I think it has been a very valuable thing in international goodwill concerning the people who visit us. As I say, we have hundreds of them, and many of them are still entertained at the expense of individual scientists. This does not represent more than a fraction of the entertainment that is involved.

Mr. BUSBEY. I have been told that here in Washington a lot of so-called goodwill is created by giving dinners and cocktail parties by individuals, organizations, and others. Does that build goodwill with those people from foreign countries?

Dr. SEBRELL. Yes. We do not limit it to people from foreign countries. There are distinguished scientists sometimes from other parts of the Nation. Very frequently they are foreigners. I have, for example, a gentleman scheduled to visit me this week, Dr. Brock, of the Union of South Africa, who is very prominent in the World Health Organization, and he is a prominent physician and scientist interested in a strange nutritional disease called Kwashiorkor. He is going to spend a couple of days with us. It is only in the natural course of things that the director will have to do some little entertaining for him.

VISITING SCIENTISTS PROGRAM

Mr. BUSBEY. What connection does this have with the visiting scientists program?

Dr. SEBRELL. That is something entirely different. The visiting scientists program we had envisioned as a program in which prominent scientists would come here to use these unusual facilities, to stay for a matter of 6 months or 1 college year and take a sabbatical leave of absence from their university teaching. They would come here right from their research work at home to use these Federal facilities to carry out a project they would not be able to do otherwise. They would at the same time be teaching our permanent staff things and we would be teaching them things so that there would be an interchange of knowledge in research projects. We have to avoid, however, duplicating health research throughout the country. The visiting scientist program has no relation to the entertainment fund at all. The visiting scientist would have purely a relationship with us to do study on those patients we would have here that they could not obtain in their own town plus the research facilities that would go with them.

Mr. BUSBEY. How much is included in the institute's budget for 1954 for this program?

Dr. SEBRELL. A very small amount of money—a few thousand dollars in each institute.

Dr. SHANNON. We can furnish that if you would like to have it.

Mr. BUSBEY. If you will.

Dr. SEBRELL. It is broken up by various institutes, but it is not a very large figure.

(The information is as follows:)

Breakdown of the NIH visiting scientist program by research institute—fiscal 1954

Visiting scientist program:	
Arthritis	$8,000
Neurology	10,000
Cancer	34,000
Mental	17,200
Heart	6,000
Dental	21,400
Total	96,600

GENERAL ADMINISTRATION

Mr. BUSBEY. How much in total do you have budgeted for "General administration," including all of your appropriations?

Dr. SEBRELL. $1,350,000.

FIELD STATIONS UNAFFECTED BY PROJECT RELOCATION PROGRAM

Mr. BUSBEY. It might be a good idea to include a brief statement on field stations that are not to be moved, including an explanation of why you feel they should be maintained as separate field stations.

Dr. SEBRELL. Yes, sir. We have several of those. I would be very glad to do that.

(The information requested is as follows:)

Research locations outside Bethesda

NATIONAL MICROBIOLOGICAL INSTITUTE

Activity	Location	Pre-clinical center positions	Post-clinical center positions	Explanation for remaining out of Bethesda
Rocky Mountain Laboratory.	Hamilton, Mont	128	128	Studies diseases common to western United States in natural habitat, not existent at National Institutes of Health, Bethesda.
Q fever studies	University of California, Hondo, Calif.	1	1	Detailed from Rocky Mountain Laboratory to use materials not available elsewhere.
Dysentery studies	Milledgeville, Ga	7	7	Studies being done in area of prime prevalence, incidence, and local importance.
Do	New Orleans, La	4	4	Do.
Do	Thomasville, Ga	3	3	Do.
Tropical disease studies	Seagoville, Tex	5		
Malaria studies	Columbia, S. C	15	15	Studies involve use of human volunteers, located in Federal prisons, which are not available at Bethesda.
Epidemiology of tropical disease.	Memphis, Tenn	20	20	Studies being done at source of greatest supply of material and data.
Tropical disease study	Harvard University, Cambridge, Mass.	1		
Influenza epidemiology	Norfolk, Va	1	1	Located at site of desirable study population with factors of numbers of people, and general living and health standards.
Cooperative tropical disease studies.	Recife, Brazil	2	2	Studies toward eradication of schistosomiasis in the area of its natural habitat.
Do	Guatemala	1		
Tropical disease study	Johns Hopkins University, Baltimore, Md.	1		

NATIONAL CANCER INSTITUTE

Laboratory of experimental oncology.	University of California, San Francisco, Calif.	20	13	To continue cooperative laboratory research with University of California staff.
Geographic and other pathology.	Warwick Clinic, Washington, D. C.	12	0	
Clinical research	U. S. Public Health Service Hospital, Baltimore, Md.	15	0	
Do	George Washington University Hospital, Washington, D. C.	8	0	
Biophysics	Carnegie Institute of Technology, Washington, D. C.	2	0	
Do	Massachusetts Institute of Technology, Cambridge, Mass.	1	1	Laboratory research with instruments and equipment not yet available to National Cancer Institute but available at Massachusetts Institute of Technology.
Do	Princeton University, Princeton, N. J.	3	1	Laboratory research in radiation studies and light in cooperation with Princeton University staff. Facilities and equipment available at Princeton University.
Cancerigenic research	Georgetown University Washington, D. C.	10	0	
Geographic pathology	Memorial Hospital, New York, N. Y.	3	3	Records of necessary population groups available only in New York City hospitals.
Clinical research	Children's Hospital, Boston, Mass.	1	0	
Pathological research	Armed Forces Institute of Pathology, Washington, D. C.	1	1	Source of material involved in cooperative study is located in Armed Forces Institute of Pathology.

NATIONAL INSTITUTE OF DENTAL RESEARCH

Activity	Location	Pre-clinical center positions	Post-clinical center positions	Explanation for remaining out of Bethesda
Oral and biological chemistry.	Staten Island, N. Y	7		
Oral bacteriology	Rochester, N. Y	3		
Fluoridation program	Grand Rapids, Mich	2	2	This study, now in its 8th year, to provide precise data on the effects of fluorides on tooth-decay rates in various age groups, is dependent upon repeated examination of the same continuous resident children of this community.

NATIONAL INSTITUTE OF MENTAL HEALTH

Addiction research	U. S. Public Health Service Hospital, Lexington, Ky.	30	30	Project will remain at Lexington, as facilities and patients are available at this location.
Juvenile drug addiction and study of mentally deficient twins.	New York, N. Y	5	2	Juvenile drug-addiction studies to be discontinued in 1954 at this project. Large population area affords best selection of material for mental-deficiency studies; also project workers make use of Columbia University case history material.
Community mental-health project.	Hagerstown, Md	2	3	This is a community study project which must be conducted in the area where study population resides.
Epidemiology	Rochester, Minn	1		
Studies on physical chemistry of proteins as related to mental illness.	Pasadena, Calif	1		
Cooperative project on ACTH.	Worcester Foundation, Worcester, Mass.	7		
Biophysics	Chicago, Ill	2		

NATIONAL HEART INSTITUTE

Gerontology	Baltimore City Hospital, Baltimore, Md.	31	31	Because of unique facilities available and moderate cost at which this study can be continued there, this project will remain at Baltimore City Hospital.
Epidemiology of cardiovascular diseases.	Framingham, Mass	20	20	This is a long-term study of a specific population and, of necessity, must remain at that location.
General medicine	U. S. Public Health Service Hospital, Baltimore, Md.	38		
Chemical pharmacology	Goldwater Memorial Hospital, New York, N. Y.	6		
Kidney and electrolyte metabolism.	Massachusetts General Hospital, Boston, Mass.	2		
Cardiovascular hemodynamics.	New York Hospital, New York, N. Y.	9		

POLICY CONCERNING REIMBURSEMENT FROM CLINICAL CENTER PATIENTS

Mr. BUDGE. Doctor, what will be your policy relative to reimbursement from patients who might be able to afford to pay? Are any of the patients at the clinical center to reimburse the Government to any extent, or is all treatment and care to be gratis?

Dr. SEBRELL. We have had long discussions over that problem, both among our own staff and with the Bureau of the Budget, and our

feeling is that it would be a mistake to try to put a per day charge on the services there for a number of reasons, one being that to do so would limit our material to people who could afford to come, and we want to study them because they have a certain disease and not a special economy group out of the population.

Mr. BUDGE. There are a great many programs, of course, that are set up for the individual to pay only if he is in a financial position to pay.

Dr. SEBRELL. We would hope such patients would make reimbursement to the Treasury if they were able to do so without our putting a specific charge on them. For one reason, the charge, since it would involve research charges, would in a sense be charging them for contributing to the research study. And many times we will hold them in the hospital when they actually do not need to be hospitalized for their own benefit but because we need to make continuing observations. And we would be in the position of charging the patient for something when he was merely contributing to the study. So we would like to have such patients in that position make voluntary contributions to the Treasury of the United States rather than trying to put any per day charge on them. We could and would be glad to make suggestions as to amounts if they felt that was indicated, but I am rather of the opinion we are going to receive many donations. The law permits us to accept donations, and we are getting them now in a small way from people who want to donate money for research in a particular project. We feel reasonably sure there will be many patients or relatives of patients who will want to subscribe to memorials through sizable contributions to advance research work. Such gifts will be deposited in the Treasury of the United States.

Mr. BUDGE. I am happy to have your statement, and I can readily see that in a great number of instances the people will be hospitalized at your convenience rather than theirs.

Dr. SEBRELL. And we want them to feel they are a part of the research team, that they are not just a subject but they are contributing something. You see, if they do not stay with us a long time, all of our research investment in the patient is going to be lost. If the patient says "I have to go because my money has run out," right in the middle of the study, we may lose thousands of dollars of research investment in that patient; whereas a few more days' observation would give us our answer. And we feel we have to do everything we can to make life so that the patient will be glad to stay until the contribution is finished. I feel very strongly we should not attempt to charge these patients and say "You have to pay so much a day or you cannot come here." I believe that would be a great mistake.

Mr. BUDGE. Of course, I do not think any of us would want to charge all of the patients to be admitted. In the high-income brackets you could perhaps not find the particular condition you wanted to explore and study, but I know the question will arise as to the reason those who can financially afford to contribute are not required to do so. I think your statement very adequately answers it.

RESEARCH FELLOWS AND CLINICAL TRAINEES WHO SUBSEQUENTLY ENTER PRIVATE PRACTICE

I am very much interested in the research program, and I am wondering about the subsidies by grants to schools and to individuals

who attend the various schools. Are there very many persons who are trained at the expense of the Government, that is, through a contribution by the Government, who just become medical practitioners or who go into a profit-making organization after they have finished the training?

Dr. SEBRELL. As Dr. Van Slyke has indicated, a very high proportion of them stay in some field of research. They do that in various places, and a number of them become teachers. Of course, as teachers they very frequently teach and do research and do a consulting practice all at the same time. That is very widely done in the American medical schools. I think a great majority of them, however, are continuing in research work. That is what they were granted for, and I think it has been very successful in having those people continue in research rather than to go off into nothing but private practice. I do not believe very many of them do that.

Do you have any figures on it, Dr. Van Slyke?

CLINICAL TRAINEES

Dr. VAN SLYKE. You are speaking about research fellowships. I think I would point out that many of the clinical trainees do go into private practice or group practice.

Mr. BUDGE. I understood you to say that was particularly true when you were discussing the psychiatrists.

Dr. VAN SLYKE. That is right. I think I can point out why we feel justified in coming before this committee and asking for funds for clinical training. If we took every single person in the United States, every physician in the United States right now who has any training in heart disease and called them all specialists whether or not they were especially competent in this very conflicting disease, but if we count every one of them as a specialist, which is not really so, even then there is only 1 specialist for every 20,000 citizens in this country. Now, it is extremely important that we have people immediately available to handle problems of heart disease, because you get on a train here tonight and you go to Chicago and at some place along the line you have to get off with the "devil's grip" in your chest from a coronary thrombosis, it is awfully important that there be some fellow in a little town along the way—not too small a town, a town of 30,000—it is awfully important that there be some kind of physician there who can give anticoagulant treatment, because it is a question of your living or dying. That is the kind of program this provides for citizens.

Mr. BUDGE. I am not so sure, though, that it is a proper function of the Federal Government to subsidize men who go out in individual practice for profit. If we have to choose between the two types of programs, our dollar can be much better spent on research programs than on the subsidization of individuals to engage in practice for profit. I hope we will get as many people that the Government is assisting to stay in the research field as possible, rather than simply permit them to get their education at the expense of the Government for their own benefit.

Mr. BUSBEY. If you will yield right there:

Doctor, I was just thinking that these boys who go to the Naval Academy at Annapolis and the academy at West Point get a very good education from the Government. But then they are required

to spend so many years in the active service and then, after that, they are subject to recall from the Reserve. Now, why should not some such formula apply to recipients of these fellowships and training grants?

Dr. VAN SLYKE. In regard to research fellowships, I do not really think you need a formula, because they are only trained in research and they will stay with it. And that is our hold on them right from the very start. If we are going to increase the amount of knowledge which springs from research, we have to have people capable of research, who are competent. And that is what we are doing. We have people who will be competent research workers in the medical program.

Mr. BUSBEY. I had more in mind the training program.

Dr. VAN SLYKE. In terms of training, I am sure you agree that is a judgmental factor, but I am inclined toward the point you expressed, Mr. Budge, that in terms of choosing, I would choose the research fellow with a love of research. On the other hand, I do not think you can dismiss the trainee as one who merely gets his education at the expense of the Government, because, as I pointed out, and our analysis has shown, these people have become especially competent in their selection, that they would become teachers in universities and medical schools. So their training is many-fold multiplied by the students which they have later.

The example I quoted specifically in answer to Mr. Budge's question was intended to show the real need for special types of service which these trainees can provide. But it does not answer the question that these people do in many instances profit financially by this training. I am quite sure that is so.

Mr. BUSBEY. These boys at Annapolis and West Point are trained for the specific purpose of defending the country. I think that the boys in this training program have just as much of a future obligation to the Government as do the boys in Annapolis and West Point.

Dr. VAN SLYKE. I agree with you completely. For the time being, at least, the doctor-draft bill takes care of those people. I mean they are obligated to serve 24 months unless there is a great physical or mental disability which lets them out.

Mr. HARLOW. But there is one slight difference, if I might suggest it. That is, these boys from West Point and Annapolis go into the service of the country, and they are on the Government payroll.

Mr. BUSBEY. If you were to ask a lot of them, I am sure you would find that they would just as soon not be on the Government payroll, with the restrictions they have to abide by under the rules and regulations for 4 years. In contrast, these other fellows are free to go and do as they please.

Mr. BUDGE. I might remark in that connection that this country has educated a great many medical men at Government expense through the Army and Navy programs, but they were all required to remain in the Reserve and practically all of them have seen active duty.

I think the chairman is certainly correct in saying there should be some requirement that these people make some contribution in this field for which the Government is spending the money to train them, and not go out and engage in private practice with the Government having paid for their education.

Dr. DEARING. May I say these programs are directed at the graduate education to develop research workers and teachers in a short field, very largely, where there is no requirement—that has been discussed many times with mental educators and others—as to whether a certain obligation of 5 or 10 years is desirable. And, as I say, there are great differences of opinion among the fields themselves on the desirability of that.

By our selection of the people, we look at their competence and their intentions, and the proof of the pudding, as Dr. Van Slyke has said, is very largely the people who do get special training, who become teachers and investigators and do stay in that field, which is a poorly paid field compared to private practice. We need our best minds in it. Some people are willing to stay in it so they can get training.

I think actually we accomplish pretty largely what you suggest should be accomplished but without any element of compulsion in it by means of signing a contract to work in it.

Mr. BUSBEY. Do you have any factual records as to the number who have received training grants who have actually stayed in the public-service field and the number who have entered private practice?

Dr. VAN SLYKE. Yes; we do have; we can supply that for the record.

Mr. BUSBEY. I would appreciate it very much.

(The information is as follows:)

Training stipend programs

	Mental	Cancer	Heart
Total trained through June 30, 1952	1,633	451	92
Post-training affiliation:			
1. Teaching (full or part time)	260	135	5
2. Other public service (full time)	665	0	10
3. Other public service (part time)	47	303	0
4. Private practice	146	3	21
5. Research	44	0	0
6. Other [1]	471	10	56

[1] Includes those still in training (although not under NIH support) and those not active in fields in which trained by reason of marriage (primarily nurses), those not active because of illness or death, and a small number of persons not responding to inquiry.

DIFFICULTIES OF INSURING TRAINEES' CONTINUANCE IN PUBLIC RESEARCH FIELD

Mr. FOGARTY. Concerning this question of teaching grants to medical schools and the traineeships and postdoctoral fellowships, I think that general program originated in this committee about 6 or 7 years ago in the cancer, heart, and mental-health fields, in which there was a known shortage of trained personnel. I think we had several people testify at that time that there was a definite shortage of technicians and medical scientists in the field of mental health and heart and cancer. As a result, the Federal Government stepped in and provided some of the funds to train young men in those fields of research.

I think it has been testified in past years that over 90 percent of those who received training under these grants continued in the field of their training. In the case of doctors who have gone to some hospital for a postdoctoral course, over 90 percent have returned to their own communities and are now heading clinics in the communities or in other ways giving the public—the taxpayer—the benefit of the training that they had received.

I think it is quite a sacrifice for a doctor to leave a thriving practice in a community and spend a year or two brushing up on the latest developments in heart, cancer, mental health, or some other medical-research field.

I remember very distinctly the testimony we have received on the shortage of psychiatrists in this country. Apparently the doctors just did not take to psychiatry, and it was brought forcibly to the attention of this committee, which is why we went into that field.

We talked about the construction of research facilities awhile ago. We have been told that if we had more facilities we would get more men interested in early life in becoming medical scientists or researchers. So, as a result, we started a construction program in heart, cancer, and mental health, which program was stopped 2 years ago, before it was completed. I think it was a $25-million program in cancer and heart; I forget the exact figure for mental health.

So it has been testified that because of the facilities that have been built by the Federal Government we did attract more people into these fields, especially in psychiatry. We have many more psychiatrists today than we had 5 years ago because of the activities of the Federal Government in this field.

As far as its being a subsidy is concerned, I do not look at it as a subsidy. As for these teaching grants to medical schools—what is it, $55,000 a year?

Dr. VAN SLYKE. $25,000 for cancer, $14,000 in heart, and the mental averages around $15,000.

Mr. FOGARTY. There is Federal control, as I understand it, only insofar as insuring that the grant shall be spent for cancer or for heart or for mental health in these particular medical schools. As a result of this help, we are turning out better trained young men, and I think this is all brought about because of the rapid advancement in medical science in the past 10 or 12 years since the beginning of the last World War. We have advanced so fast in some of the fields that the ordinary practitioner has not been able to keep up with the advances that have been made.

Perhaps you can tell one of these trainees or fellows that he has got to serve at least 5 years in that particular field if he gets 2 years of training at $3,200 a year from the Government, but I think there is a lot of difference between this program and the boys going to Annapolis or West Point. I know that long-term service could not be secured under the old training program that we had for nurses in the last World War. That was one of the reasons why the program died as the war ended—because there was no way to be found whereby you could put under contract a girl who was going to study to be a nurse and was getting some governmental assistance. You could not very well tell her that she could not get married or, if she did get married, that she was not going to have any children for a period of 4 or 5 years. That was one of the difficulties that we ran up against in that program.

DELAY IN OPENING OF CLINICAL CENTER

The delay in opening the clinical center bothers me, as it does the chairman. I was on this committee in 1947 and 1948 when this committee started the building program, which we did when there

was the same demand for cutting Federal expenditures that we have today. These budgets were cut in other programs, but we embarked in 1947 on this building project that has cost us over $60 million. As I understand it, there is not anything like it in the world. I think the Bureau of the Budget is going pretty far afield when it holds up something that the past Congresses, both Republican and Democratic, have clearly indicated that they want to go ahead. Without a dissenting voice, it expressed its desire to have this center get started this year.

As I understand it, this directive was issued by the Director of the Budget sometime in February, preventing you from going over your January rate of expenditures and preventing the hiring of new people. But there was something in the directive which said that, if the Administrator thought that it was in the best interests of the Government and of the people, she could clear it, and I think the Administrator did clear it and then went back to the Bureau of the Budget with that request. Now they come back and say, "No; you had better hold it up until we decide how much you are going to have to operate with in 1954."

The Bureau of the Budget is not the one who determines how much you are going to have to operate with in 1954. It is the Congress of the United States that determines how much you are going to have to operate with in 1954. They only make recommendations. The Congress has already made a determination for this fiscal year, believing what you said a year ago that you could open this clinical facility in the month of April. Based on what you told us and the appropriations we made, Congress expected that you would have 150 beds in operation by July 1. Now, if the Bureau of the Budget is going to have its way, you are not going to open on July 1. You are not going to have one bed occupied on July 1, because you will not know how much money you are going to have to operate with in 1954 until the bill is signed by the President, and that will be nearly July 1 or perhaps even later. If that is so, 60 days after July 1 will bring you up to September 1.

As a result of the action of the Bureau of the Budget, the opening of this clinical facility is being delayed not for 1 month but for 4 or 5 months, as I see it, because they are not going to determine how much you are going to operate this with in 1954; it is not going to be known definitely until June or July when this bill will have passed both Houses of Congress.

Mr. BUSBEY. Will the gentleman yield briefly?

Mr. FOGARTY. Yes.

Mr. BUSBEY. Although it may come as a shock to a great many people when they read the record, nevertheless I would like the record to show that I agree 100 percent with what the gentleman from Rhode Island, Mr. Fogarty, has said about the opening of this clinical center in Bethesda.

Dr. SEBRELL. I would like to point out, of course, that the communication from the Director of the Bureau of the Budget was a suggestion. He suggested that the clinical center not be opened until the 1954 budget was determined.

Mr. FOGARTY. What can any man working for the Government do when the Bureau of the Budget suggests anything? That is a

directive as far as the employees in the executive branch are concerned, and they know that at the Bureau of the Budget, too.

DEVELOPMENT OF ELECTROKYMOGRAPH

Now, with reference to some of the work done under these grants, Dr. Shannon, you had someone working with you on a machine, at the Heart Institute, called the electrokymograph, is that right?

Dr. SHANNON. Yes.

Mr. FOGARTY. Was not the development of that particular machine the result of a grant to a medical school or laboratory?

Dr. SHANNON. That is right. It was as a result of a cooperative research program in part between the Public Health Service and in part Temple University, School of Medicine, where Temple shared part of the cost and Public Health Service covered the rest.

Mr. FOGARTY. And as a result of that, this machine has been built?

Dr. SHANNON. Yes, sir.

Mr. FOGARTY. Tell us what it does and what you have done with it. Have you made any improvements in it?

Dr. SHANNON. The machine is a device which permits the recording of the movement of the heart's borders through electrical currents. It has certain aspects that are similar to the conventional electrocardiogram, except that the electrocardiogram records electrical events and this records mechanical events. This permits the study of a combination of the two events. Through it we can obtain new information on the various types of heart disease and thereby acquire a better understanding of the mechanical disability which results from these disturbances in heart muscle.

I do not believe now, from what we know, that it ever will be a routine instrument as is the case of the electrocardiogram, but we are sure that it is very valuable and will continue to be a very valuable research instrument.

WORK ON ACTH AND CORTISONE

Mr. FOGARTY. What are you doing in your research to develop a synthetic process of manufacturing ACTH and cortisone? You have done some work in that field?

Dr. SEBRELL. Yes. We have some chemists in that field who are working on the complete synthesis of the compound, trying to find primarily a cheaper way of making it, because it has been rather an expensive drug.

Mr. FOGARTY. What was the original cost of a gram and what is it today?

Dr. SEBRELL. It started out at more than $200 a gram when it was first put on the market, and it has dropped now to about $12 a gram.

You may remember that when this first came out we collaborated with the Department of Agriculture in trying to find a native plant source. This cortisone, as it was originally manufactured, was made from bile from slaughterhouses, and that material is naturally limited and expensive, so we set about finding a plant source for it. It was known to exist in certain forms of strophanthus which grows in Africa and which has been used in arrow poisons. It was found, but not in

practical amounts. In the meantime, a possible new source has been developed from some large yams in Mexico.

The work in trying to find a proper method of synthesizing it from some plant source is still going on with our chemists. We have not found anything yet that is of any practical value.

COMPOUND F

Mr. FOGARTY. What about that new compound you spoke of a year ago, compound F?

Dr. SEBRELL. Compound F is a hydrocortisone. It is a compound closely related to the present cortisone that can be made by a somewhat similar chemical process and may have some additional advantages over cortisone. It is, in general, somewhat similar to its action. It is being put up now into some ointments for possible use in skin disease, and I believe it was injected into some joints directly for a while. That is being tried as a means of treating some forms of arthritis.

GRANTS-IN-AID TO STATES

Mr. FOGARTY. This area of grants to States is getting to be a problem, but I understand the President is about to appoint a Commission to study the Federal-State relationships not only in grants, but also in taxation; and I suppose that committee will come up with some recommendations and policy will be established by the administration.

I remember about 7 years ago we went over the Bureau of the Budget figures to provide a demonstration team for every State in the Union for the development of mass X-rays for the purpose of finding those who had some form of TB. As a result of the Federal Government getting started in that field, we find now that most States have similar teams in their own communities. That was because of the leadership of the Federal Government. In my opinion, that has paid off a hundredfold in the discovery of cases, because there is not much you can do about TB unless you find it early, but if you find it in the early stages you can cure it.

I remember this committee going over the budget figures to provide demonstration teams in the application of sodium fluoride to children's teeth. As a result of research done by the Public Health Service, we now find that many communities in the country are adding this fluoride to their drinking water supply and that is effecting the saving of millions of dollars in the care of children's teeth. That was a direct result of the application of the finding of the Public Health Service and appropriating funds to get this information out to the States as quickly as possible.

If there is to be some change in policy regarding grants to States by this administration, it seems to me that the only fair approach to the problem would be a gradual process and by informing the States ahead of time what to expect in this particular field and then at the same time determining whether or not they are going to take up where we leave off in these particular fields. That is giving me quite some concern, because I do not think these grants should be cut off without the States having advance notice so that their legislatures can meet

and they can determine for themselves what they want to do with regard to State financing.

But that is a big overall program. It is a study that will take a lot of time if it is done right. It is called a subsidy. Perhaps every subsidy ought to be investigated by the Federal Government.

That is all, Mr. Chairman.

RESEARCH FELLOWSHIP AND TRAINING STIPEND PROGRAMS

Mr. BUSBEY. I am sure both Mr. Fogarty and Dr. Dearing did not want to leave the impression in the record that there was any intention of having these recipients of training grants sign up for any 5- or 10-year period; I do not believe there was any mention of any specific term of years for which they would be required to sign up. It was just the matter of principle. I am sure I did not specify any particular length of time; neither did Mr. Budge. But inasmuch as there had been reference to having people sign up for 5 or 10 years, I thought I had better see that the record was clear.

Mr. BUDGE. Mr. Chairman, in that connection, the reason I asked the question as to what happened to the people is because of testimony here to the effect that many of the students studying psychiatry under this program were going into the private practice of psychiatry. I wanted to know just what happened to the people whom we trained, and whether they went into something else than what we are spending this money for.

Mr. BUSBEY. I think we were all interested in that. But I wanted the record to show that there was nothing said on your part or mine to indicate that it was our opinion these recipients should be required to stay in the research field for 5 or 10 years or any specific length of time.

Are there any further questions?

Dr. SEBRELL. Mr. Chairman, may I extend to you and to the members of the committee a cordial invitation to visit the National Institutes of Health? We would be delighted to have you at any time and show you anything you would like to see.

Mr. BUSBEY. Dr. Sebrell, I might say that we are aware of the fact that we always have had a welcome awaiting us at the institutes. We have been trying to set aside a day when the committee could go out and spend the entire day. We have not arrived at that day yet, but I do hope we will soon.

Mr. FOGARTY. I do think we should go out and see the clinical center now that construction has been completed.

Mr. BUSBEY. The committee will stand adjourned.

NATIONAL CANCER INSTITUTE

WITNESS

DR. JOHN R. HELLER, DIRECTOR, NATIONAL CANCER INSTITUTE

SALARIES, EXPENSES, AND GRANTS

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$15,031,750	$17,887,000	$22,000,000
Transferred to—			
"Salaries and expenses, defense production activities, Federal Security Agency," pursuant to Public Law 253	−24,000		
"Hospitals and medical care, Public Health Service," pursuant to Public Law 375	−125,000		
Adjusted appropriation or estimate	14,882,750	17,887,000	22,000,000
Reimbursements from non-Federal sources	1,534		
Reimbursements from other accounts	19,585	20,500	
Total available for obligation	14,903,869	17,907,500	22,000,000
Unobligated balance, estimated savings	−102,129		
Obligations incurred	14,801,740	17,907,500	22,000,000
Comparative transfer to—			
"Assistance to States, general, Public Health Service"	−43,930		
"Hospitals and medical care, Public Health Service"	−202,360	−195,000	
"Neurology and blindness activities, Public Health Service"	−119,446	−170,000	
"Salaries and expenses, Office of the General Counsel, Office of the Administrator, Federal Security Agency"		−2,800	
Total obligations	14,436,004	17,539,700	22,000,000

NOTE.—Reimbursements from non-Federal sources above are from the proceeds of sale of personal property (40 U. S. C. 481 (c)).

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
Direct obligations			
1. Grants:			
(a) Grants for research and training:			
(1) Research projects	$2,978,053	$4,750,000	$4,734,000
(2) Research fellowships	499,274	625,000	514,000
(3) Teaching of medical subjects	2,039,016	2,225,000	2,225,000
(4) Training stipends	374,960	500,000	500,000
(5) Construction of research facilities			4,000,000
(b) Grants for detection, diagnosis, and other control services	2,923,100	3,050,000	3,000,000
(c) Grants for special control projects	899,460	900,000	900,000
2. Direct operations:			
(a) Research	3,924,586	4,617,600	5,277,000
(b) Other direct operations:			
(1) Technical assistance to States	398,128	400,000	400,000
(2) Review and approval of research and training grants	81,090	108,000	100,000
(3) Administration	298,752	343,600	350,000
Total direct obligations	14,416,419	17,519,200	22,000,000
Obligations payable out of reimbursements from other accounts			
2. Direct operations:			
(a) Research	19,585	20,500	
Total obligations	14,436,004	17,539,700	22,000,000

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Summary of Personal Services			
Total number of permanent positions	583	648	641
Full-time equivalent of all other positions	9	12	14
Average number of all employees	548	592	612
Average salaries and grades:			
General schedule grades:			
Average salary	$4,609	$4,711	$4,724
Average grade	GS–6.5	GS–6.6	GS–6.6
Crafts, protective, and custodial grades:			
Average salary	$2,800	$2,851	$2,851
Average grade	CPC–3.1	CPC–3.2	CPC–3.2
Personal service obligations:			
Permanent positions	$2,564,897	$2,869,832	$2,999,832
Part-time and temporary positions	46,768	62,900	73,700
Regular pay in excess of 52-week base	9,154	9,361	9,361
Payment above basic rates	17,659	18,177	18,177
Total personal service obligations	2,638,478	2,960,270	3,101,070
Direct Obligations			
01 Personal services	2,629,213	2,948,070	3,101,070
02 Travel	72,899	88,400	91,000
03 Transportation of things	12,984	11,600	11,600
04 Communication services	15,897	16,600	16,600
05 Rents and utility services	3,702	3,200	2,900
06 Printing and reproduction	74,209	70,700	70,700
07 Other contractual services	225,113	189,000	146,500
Reimbursements to "Operating expenses, National Institutes of Health, Public Health Service"	1,070,850	1,614,000	2,121,700
08 Supplies and materials	281,659	298,000	331,000
09 Equipment	314,457	224,700	227,500
11 Grants, subsidies, and contributions	9,713,863	12,050,000	15,873,000
13 Refunds, awards, and indemnities	35		
15 Taxes and assessments	5,781	8,750	10,250
Subtotal	14,420,662	17,523,920	22,004,720
Deduct charges for quarters and subsistence	4,243	4,720	4,720
Total direct obligations	14,416,419	17,519,200	22,000,000
Obligations Payable Out of Reimbursements From Other Accounts			
01 Personal services	9,265	12,200	
03 Transportation of things	107		
06 Printing and reproduction	30		
07 Other contractual services	5		
08 Supplies and materials	5,102	4,300	
09 Equipment	5,076	4,000	
Total obligations payable out of reimbursements from other accounts	19,585	20,500	
Total obligations	14,436,004	17,539,700	22,000,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$8,743,025	$2,614,109	$3,641,109
Obligations incurred during the year	14,801,740	17,907,500	22,000,000
	23,544,765	20,521,609	25,641,109
Deduct:			
Reimbursable obligations	21,119	20,500	
Adjustment in obligations of prior years	844,566		
Unliquidated obligations, end of year	2,614,109	3,641,109	8,151,109
Obligations transferred to "Salaries, expenses, and grants, National Cancer Institute (liquidation of contract authorization), Public Health Service"	4,625,000		
Obligated balance carried to certified claims account	2,457		
Total expenditures	15,437,514	16,860,000	17,490,000
Expenditures are distributed as follows:			
Out of current authorizations	12,334,930	14,900,000	14,760,000
Out of prior authorizations	3,102,584	1,960,000	2,730,000

Amounts available for liquidation of contract authorization

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$4,625,000		
Applied to contract authorization	−4,625,000		
Obligations incurred			

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$2,065,066	$3,928,711	$1,100,000
Obligations transferred from "Salaries, expenses, and grants, National Cancer Institute, Public Health Service"	4,625,000		
	6,690,066	3,928,711	1,100,000
Deduct unliquidated obligations, end of year	3,928,711	1,100,000	
Total expenditures	2,761,355	2,828,711	1,100,000
Expenditures are distributed as follows:			
Out of appropriations to liquidate prior-year contract authorization	923,000		
Out of prior authorizations	1,838,355	2,828,711	1,100,000

Mr. BUSBEY. We have under consideration the appropriation request for fiscal year 1954 for "Salaries, expenses and grants, National Cancer Institute."

Dr. Heller, we welcome you back to the committee and will be very happy to hear from you at this time.

GENERAL STATEMENT

Dr. HELLER. Thank you.

Mr. Chairman and members of the Committee, may I first express my appreciation for the opportunity to advise you of the activities of the National Cancer Institute. This privilege has been afforded me on several occasions in the past, and it is always a pleasure to present our program to you and to answer any questions you may have concerning the details of our work.

Cancer, as you know, is the second leading cause of death from disease in the United States. While usually regarded as a chronic and degenerative disease, cancer is really many diseases with clinical manifestations as varied and baffling as are found in any of the ills of mankind. Some types of cancer, for example, leukemia, may have a course as acute and swift as that of a violent communicable disease like typhoid. Some types of malignant tumors, on the other hand, are slow growing, concealing their presence for dangerously long periods. Some, depending on stage of development can be destroyed by surgical or radiation treatment while others cannot.

It is not strange that the attention of scientists should be directed more and more toward the study of cancer. The control of infectious and communicable diseases through medical research, medical practice, and public-health work has enabled additional resources of manpower, facilities, skills, and knowledge to be focused on the problem.

Cancer is one of the most formidable challenges in medicine. Mankind has grappled with it from the earliest times for which medical records are available. Consequently the history of medical research

reflects and records the search for facts about cancer and the trial-and-error approach for control.

Unlike other diseases, cancer is a type of body reaction and results from probable interaction of a number of factors which provide a wide manifestation of clinical changes. The common denominator, however, in this type of body response is the cellular change which we call malignant transformation.

This denotes the multiplication, the differentiation and the organization of cells in the body which, reduced to a simple word, means growth. The fundamental element, therefore, in the study of cancer is growth.

Because of the scope and complexity of this problem, investigators are faced with the need for interdisciplinary effort. Biochemists, physicists, geneticists, pathologists, clinicians, and many other specialists must work one with another toward the common goal. This coordination and harmony of effort is being effected to an increasingly favorable degree in the United States.

PROGRAM OF NATIONAL CANCER INSTITUTE

The program of the National Cancer Institute is a three-pronged attack on cancer. Funds made available by Congress in the past have been used for research within the National Cancer Institute itself, to support research in institutions outside the National Cancer Institute, and to assist in making possible the more effective and widespread use of presently known methods of cancer diagnosis and treatment.

The attack against cancer in this country has now assumed the proportions of a mass attack. It reaches out into practically every institution possessing scientific manpower and facilities adaptable to research in the field of cancer.

It is recognized that this mass attack can proceed no faster than the trained manpower and facilities available. The program of the National Cancer Institute embraces, therefore, activities which promote, develop, and maintain all elements involved in the diagnosis, treatment, and prevention of cancer.

COOPERATION OF NATIONAL CANCER SOCIETY

The American Cancer Society, the major voluntary organization in the cancer field, has worked closely with the National Cancer Institute in all phases of the program. There has been free exchange of information and cooperation between the two national groups at all times. In this way unnecessary duplication on a national basis is avoided and economy is effected.

DIRECT RESEARCH ACTIVITIES OF INSTITUTE

Direct research activities at the National Cancer Institute have as their basis of approach the acquisition of factual information obtained from the study of experimental and clinical cancer. Many research categories are involved in obtaining this information and large masses of data have accrued from the study of experimental neoplasms. The availability of long-needed clinical facilities provided by the new clinical center of the National Institutes of Health will make it possible to obtain similar information on human cancers in order to affirm or deny the soundness of the basic approach and to ob-

tain further knowledge and practice in the control and prevention of cancer in the human.

One group of scientists at the National Cancer Institute is investigating the appearance and microscopic arrangement of cells and tissues in the development of cancer. Another group is screening drugs to find out which ones can inhibit the growth of tumors. Other scientists are exploring the role of endocrine glands and hormones in the development and clinical course of cancer. Biologists are studying the delicate structure of the cell to see what happens in the chemistry of the cell when it changes from normal to malignant to learn more about the influence of heredity on the occurrence of cancer and to see how the cancer cell sustains itself.

Research at the National Cancer Institute is an important part of the worldwide attack on cancer. It is essential that our scientists be well informed of progress made by investigators in other institutions in order to avoid undesirable duplication of effort and unnecessary persistence in an approach that has been successsfully mastered or shown to be fundamentally unsound in other laboratories. Our program is being continually reevaluated and reoriented in the light of worldwide experience. We are very proud of the original accomplishments of scientists at the National Cancer Institute and of the impetus which our work furnishes cancer research in other laboratories.

GRANTS TO NONGOVERNMENTAL AGENCIES

Support to agencies and institutions outside of Government for cancer work has been extended during the past year. Grants of one type or another have been made to practically all organizations and institutions in the Nation that have appropriate facilities and personnel to collaborate in solving the problem. The immediate goal of this activity is the cumulative acceleration of the national program of cancer research. There has been a gradual increase in the number of scientists trained in the various disciplines necessary to cancer research and additional facilities have become available, many as a result of the construction grant program initiated in 1948. Discoveries in the field of atomic energy have brought about possible application of several exciting facets of this new area to the study of the diagnosis and treatment of cancer.

RESEARCH FELLOWSHIP PROGRAM

In the fellowship program since its inception in 1938, there have been 790 young men and women who have been supported in their training to become research scientists. In addition, since 1938, 531 young physicians have received specialized training in surgery, medicine, pathology or radiology in institutions throughout the country in order that there may be an improvement in the management and care of cancer patients in hospitals and clinics.

CANCER CONTROL ACTIVITIES

In contrast to the long-range research effort to solve the problem of cancer, cancer control activities are primarily aimed at the most immediate use possible of the knowledges, skills and techniques developed in research. Cancer control, therefore, is regarded as an activity that

must be suitably integrated with cancer research efforts. The two cannot be separated if effective results are to be achieved. At the present stage of development the control program may be regarded as a continuation of research or, in a sense, as applied research.

From the public health viewpoint, cancer control presents a new concept which must be effected by diverse means. It is not simply a matter of instituting sanitary or other improvements that control the spread of disease. One problem is peculiar to a cancer control program. It stems from the fact that cancer may occur anywhere in the body and the symptoms and course vary with the site of the tumor. This furthers the concept that cancer is many diseases rather than a single disease.

RECENT SURVEYS

One of the primary requisites for the effective control of cancer is a knowledge of the nature and scope of the problem. Surveys have been completed in 10 representative metropolitan areas of the United States in which similar studies were made 10 years ago. In addition to providing current information on the cancer problem, the surveys provide comparative data for a decade. From such studies of the occurrence of cancer, more and better information is available of the morbidity and mortality of cancer throughout the nation.

Of the small number of different types of cancer that have a known or even a suspected cause, most appear to be the result of continued or intermittent exposure to active physical, chemical or biologic agents of the environment. The initiation of measures which reduce or eliminate harmful exposure is an activity which is an important sequel to the investigation and determination of facts involving the production of cancer from such exposure.

CONSULTATION SERVICES

Consultation services are rendered by National Cancer Institute staff to both official and voluntary agencies in the promotion, development, and operation of cancer control programs. Diagnostic clinics have been established and case registries initiated in hospitals, while refresher courses for physicians and many other control procedures have been undertaken by States through grants-in-aid.

ACCOMPLISHMENTS

I should like to conclude this statement by citing a few of the specific accomplishments of current cancer research and control programs. Encouraging progress has been made in the development of better methods for the treatment of cancer. Techniques for more extensive surgery have been perfected. Knowledge of the physiologic limits of surgery has become more exact. Other advances have been made which contribute to improvements in cancer surgery, such as better pre- and post-operative care, better anesthesia, control of infections by antibiotics, better understanding of the role of body fluids in disease, and improved control of shock by blood transfusions. As a result, a great variety of cases of cancer that once were considered inoperable and hopeless may now undergo surgery with good chances of survival.

Numerous technical advances have been made in radiation therapy. In the old days the radiologist had at his disposal only radium, radon,

and medium voltage X-ray machines. Now he has not only those but also powerful machines such as the supervoltage or multimillion-volt X-ray generators, new types of radiation from the betatron and the cyclotron, and a number of new radioactive substances like radioactive cobalt and the radioisotopes supplied by the Atomic Energy Commission. Encouraging improvements in the treatment of cancer with these new weapons have been noted.

One of the most encouraging aspects of cancer therapy is the rapid development of new chemical agents. None has achieved the status of a cure, but treatment of cancer with drugs has been established as a valuable adjunct to surgery and radiation. Among the most promising anticancer drugs are the folic acid antagonists which are widely used in the treatment of acute leukemia in children. These antifolics have prolonged the lives of some children and brought about temporary clinical improvements in many. Wide clinical trials are being given other anticancer drugs such as the nitrogen mustards and triethylene melamine.

Much has been learned about the use of hormones in cancer therapy. Dr. Charles Huggins has demonstrated that induced imbalances of hormones may have marked effects on some kinds of cancer. The growth of cancers of the prostate has been stopped by castration and administration of female sex hormones. Another tool for controlling prostatic cancer is a new surgical procedure called adrenalectomy. Dr. Roy Hertz of the National Cancer Institute has found that hormones may be used to prepare certain cancer patients for surgery. In some cases he has been able to shrink uterine cancers by administration of progesterone. Doses of a water-soluble form of estrogen (female sex hormone) have been given, with good effect to patients with cancer of the breast and prostate.

EARLY DISCOVERY TECHNIQUES

Advances have been made in techniques for the early discovery of cancer which have contributed to saving or prolonging the lives of many cancer patients, particularly women with cervical cancer or cancer of the breast. In addition to biopsy, the most practical technique is the cytologic test developed by Papanicolaou, which is particularly useful as an aid to the diagnosis of cervical cancer. Theoretically, this test is applicable to any of the body excretions. At present it is applied with greatest success as a test for cancer of the uterine cervix and the lung. We are supporting projects to see if the cytologic test can be used as a mass-screening method to find cancer in large segments of our population. More and more physicians and technicians are being trained in how to use the test and interpret its findings.

BASIC RESEARCH STUDIES

Basic studies in cancer research have done much to increase our understanding of how cancers are caused and how they develop. Among the notable advances are those in tissue culture laboratories. More effective use of tissue culture in the study of normal and cancer cells has been made possible by the three-dimensional tissue culture technique developed by Dr. Wilton Earle at the National Cancer Institute. Many applications for this technique are foreseeable. Already it has been applied in collaborative studies with the Naval Medical

Research Institute to obtain large cultures of human epithelial cells for skin grafting purposes.

Very rapidly following World War II the number of cancer studies multiplied and the supply of scientific manpower increased, but expansion of cancer research in the United States was hindered by the lack of physical facilities. To remove this bottleneck to further expansion, the Congress authorized a construction grant program to be carried out by the National Cancer Institute. Within 3 years support was given to the building of urgently needed clinical and laboratory facilities for cancer research at 49 non-Federal institutions in 27 States and the District of Columbia. Not only have a number of existing cancer research centers been expanded, but new centers for cancer research have been created also, greatly reinforcing the nationwide attack on cancer.

Mr. Chairman, I hope that this statement will serve the purposes of the committee. I shall be only too pleased to supplement or augment it in any respects you may desire, and to answer any questions that the Members may have concerning our work. Again, permit me to express my appreciation for this opportunity to be of service to you.

COOPERATION BETWEEN INSTITUTE AND AMERICAN CANCER SOCIETY

Mr. BUSBEY. Dr. Heller, I wonder if you might explain in more detail the cooperation between the National Cancer Institute and the American Cancer Society that you referred to briefly in your opening statement?

Dr. HELLER. Gladly, Mr. Chairman. The American Cancer Society which, as you know, is the principal unofficial or volunteer organization in the country, consists of both medical and lay people prominent in business and professional circles throughout the country. The program which has been set forth by the group has been established through the approval of the board of directors. I happen to be one of those named on the board of directors which enables, in this instance, the National Cancer Institute to be fully and thoroughly apprised of the deliberations and to participate. So if I, as a representative of the National Cancer Institute, see or sense some project or element which is a duplication of something we are doing, I am able to draw their attention to it.

Similarly, the representatives of the American Cancer Society are members of certain of our committees and attend, upon invitation, council meetings and have a similar function in studying what is going on in the grant programs which the National Cancer Institute and Public Health Service undertake.

We work very closely on such projects as lay education and professional education which I believe to be one of the areas in which the greatest duplication might be found. We attempt to collaborate and do collaborate on educational materials such as films in which it is far cheaper for us to go in together and come out with a really good film than for each of us to try to make its own film.

Similarly, in the production of certain educational material, particularly for lay people, we collaborate in the same manner. So that educational materials which are put out are the joint effort of the two national groups and go out to all parts of the country, distributed by the State health departments, the official agencies through which we

operate, and through divisions of the American Cancer Society as normal functions of units or State divisions of the national organization.

In this way we believe, and experience has demonstrated, that there is a minimum of difficulty and any duplications or any elements which seem to be duplications very quickly are worked out and do not exist at the national level. I think this has been a very successful and worthwhile cooperation and collaboration venture.

EXPENDITURES OF AMERICAN CANCER SOCIETY

Mr. BUSBEY. Do you have any idea how much the American Cancer Society spends in the course of a year?

Dr. HELLER. Their fund this last year was something of the order of $16 million, of which 25 percent was automatically earmarked for research and 60 percent of those funds go back to the States and local divisions of the American Cancer Society, with the remaining 15 percent going to administration and for the production of materials and certain other expenses of the national organization.

FUNDS REQUESTED OF BUDGET BUREAU

Mr. BUSBEY. Your request for fiscal year 1954 is $22 million?

Dr. HELLER. Correct.

Mr. BUSBEY. That amounts to an increase of $4,113,000. However, taking into consideration the comparative transfers, the actual increase for this activity is $4,480,800. For what did you ask the Bureau of the Budget for the National Cancer Institute?

Dr. HELLER. We asked the Bureau of the Budget in the A and B budgets for $19,497,200.

COMPARATIVE TRANSFERS

Mr. BUSBEY. Will you explain briefly each of these three transfers?

Dr. HELLER. Yes, sir. A number of years ago there was established at the Baltimore then marine hospital, now the Public Health Service Hospital, a tumor service for the study, management, and cure of persons, beneficiaries of the service primarily but also other study patients who have cancers. This has been a very successful venture, and over a period of years has become very well known and highly regarded professionally as serving an extremely useful purpose.

The National Cancer Institute has utilized this material for study, and the clinic has served as a focus of a clinical investigation unit in Baltimore. With the opening of the clinical center, it seems desirable and reasonable that this particular activity should be operated by the Public Health Service hospital in Baltimore and, accordingly, the cost of this, which previously had been borne by the National Cancer Institute, is designed as a comparative transfer to the Bureau of Medical Services to the extent of $195,000. In the next item, "Neurology and blindness activities of the Public Health Service, there were a number of grants which were of great interest to cancer and of great interest to neurology and blindness. In order that these grants might be supported, they were recommended to the Surgeon General by the National Advisory Cancer Council, and, when the Neurology

and Blindness Institute became an entity of the National Institutes of Health, a number of these projects were of even greater importance to neurology and blindness. While still of significance to the National Cancer Institute, these grants were thought to be of greater value and interest or as great value and interest to neurology and blindness and therefore were transferred.

The third item of "Salaries and expenses, Office of the General Counsel" was a sum of $2,800 which was our part of the support of legal services in which the National Institutes of Health participates.

NEED FOR LARGE NUMBER OF COMPARATIVE TRANSFERS

Mr. BUSBEY. Mr. Harlow, these comparative transfers are very confusing to me. Would you tell the committee why every year there are about 25 or more comparative transfers in the budget of the Public Health Service.

Mr. HARLOW. I suppose the shortest answer I could give to that would be to say we are not a static organization. In fact, we rather take pride in the fact that we are a dynamic organization. As these shifts in programs occur and as these things happen as they do, we think it is quite proper that we should, through the budget process, call the attention of the committee to these matters and ask that the funds be transferred as the functions are shifted.

Of course, with respect to this neurology and blindness item, we might give the credit to Congress there, because the Surgeon General was directed to set up this new institute. And in order to do so, he took funds that had been appropriated under other titles, turned them over to the Neurology and Blindness Institute. At this first opportunity we have come up to you and show how much money had been turned over to that institute as a result of this congressional directive.

The situation at Baltimore has come to a head, of course, because of the establishment of the clinical center. The research money has been pulled out of the Baltimore Marine Hospital and used in the clinical center with the transfer to the Hospital Division of the funds that are used there for the operation of the treatment clinic.

BUDGET INCREASE FOR CLINICAL CENTER ACTIVITIES

Mr. BUSBEY. Speaking of the clinical center, how much of the increase in this budget is directly attributable to the opening of the clinical center?

Mr. HARLOW. Are you speaking of the National Cancer Institute budget or the whole budget?

Mr. BUSBEY. The National Cancer Institute budget.

Mr. HARLOW. I think Dr. Heller has those figures.

Dr. HELLER. Yes. The net increase due to the clinical center is $665,800.

Mr. BUSBEY. Will that amount be reduced any due to the delay in opening the clinical center?

Dr. HELLER. I am not sure of that yet. It has not been established, and I would not be able to answer that completely.

Dr. SEBRELL. If I may supplement the answer for you, the delay in opening the clinical center we anticipate will affect only this year's

budget, because even though we may not start until the 1st of July or after the 1st of July, we expect to accelerate our buildup of patients; so the total amount of funds involved probably won't be any less as we accelerate. It may make some difference, but we cannot calculate what it might be.

CANCER RESEARCH OF ATOMIC ENERGY COMMISSION

Mr. BUSBEY. What is the Atomic Energy Commission doing in the field of cancer research?

Dr. HELLER. The Atomic Energy Commission has several facilities—Oak Ridge, Tenn., Argonne, Chicago, and Brookhaven, N. Y., being the principal ones—in which some very basic work is being done in the preparation of radioactive isotopes. Some of those radioactive isotopes are very short-lived: that is, a half life, which is the usual term that is used in measuring them—may be even a matter of a minute or 2 minutes. And in order to take advantage of the wonderful opportunity to study the effects of some of those isotopes on tumors, they have established cancer hospitals or cancer clinics directly in the centers.

As a matter of fact, at each of those three major facilities of the Atomic Energy Commission, they do have cancer clinics and cancer hospitals to which patients may go. It is a cooperative arrangement worked out through the medical schools of the area. They work very closely with us and with other institutions throughout the country in furnishing some radioactive isotopes which have a longer half life, of a few days or even a few years, so that other institutions can study them as well.

Their interest in cancer is primarily general. They have developed radioactive cobalt, about which you may have read, and a unit I believe has been established by the Montefiore Hospital in New York and 1 or 2 other places in the country. It is alleged that the cobalt isotope is perhaps going to supplant radium in the days to come, because it is cheaper and a little more flexible in its use.

In general, that has been the role and the interest of the Atomic Energy Commission in cancer research.

HOSPITAL FACILITIES

Mr. BUSBEY. How many hospital facilities does the Atomic Energy Commission own?

Dr. HELLER. As far as my knowledge goes—and I think it is correct—they have three. They are comparatively small institutions. They have one at Oak Ridge, one at Brookhaven of smaller size, and the one at the Argonne Laboratory, Chicago, is slightly larger. That one is part of the University of Chicago setup or at least closely cooperating with them. My impression is there are 25 or 30 beds in each facility. They are comparatively small but ample for the purposes they have in mind, as I understand it.

Mr. BUSBEY. Do you have any idea of approximately how much money they are spending in this field?

Dr. HELLER. No, sir; I do not, because from our viewpoint it is very difficult—and I suppose from theirs—to separate exactly cancer and other developmental procedures.

Radiological Work of Public Health Service

Mr. Busbey. As we have gone through these hearings, I have noticed in the verbal, and also the written justifications, many references to radiological work. I think it would be well to have prepared a statement showing how much money is being spent on this work in 1953 under each appropriation in the Public Health Service and the total for the Service, the amounts budgeted for 1954, and a brief description of this work under each appropriation. Also include a statement on how this work is coordinated with other radiological work in the Federal Government in order to avoid duplication and what steps are taken to avoid doing work which could be done outside the Federal Government at a saving to the Federal Treasury.

Dr. Scheele. In that connection, the committee would be interested in knowing we are releasing, I believe, $800,000 of the money appropriated for the acquisition of a high-voltage generator so that we will actually not be working as intensively in the field of radiation studies as was earlier planned in the new clinical center. This is 1953 money which will not be spent and will lapse.

(The requested information follows:)

Radiological Work in the Public Health Service

I. SUMMARY

Appropriations

	1953	1954
To Bureau of State Services: "Engineering, sanitation, and industrial hygiene, Public Health Service"	$356,000	$355,000
To National Institutes of Health:		
"Salaries, expenses, and grants, National Cancer Institute, Public Health Service"	260,000	350,000
"Arthritis and metabolic-disease activities, Public Health Service"	225,000	225,000
Total	841,000	930,000

Radiological work in the Public Health Service is of two general types: (1) Laboratory studies of the effects of radiation upon biological substances, systems, and animals; and (2) studies of various aspects of public-health protection against radiation hazards.

The laboratory aspects of radiology are carried on in National Institutes of Health laboratories, under two appropriations: National Cancer Institute and National Institute of Arthritis and Metabolic Diseases. The cost will be $485,000 in 1953 and $575,000 in 1954. The increase will be the net result of a contraction of laboratory research in the Cancer Institute and an expansion of clinical work of this Institute in the clinical center on radiological problems.

The public-health aspects of the work are carried on in the Bureau of State Services under one appropriation, "Engineering, sanitation, and industrial hygiene." Work supported in this field during 1953 from this appropriation totals $356,000. The estimate for 1954 is $355,000.

Wide differences in the objectives, approaches, skills, and relationships required for dealing effectively with the many aspects of radiology account for activities in this field in two Public Health Service bureaus.

All work in this area is fully coordinated with the Atomic Energy Commission and appropriate parts of the Department of Defense. Public Health Service staff serve on a network of coordinating bodies. (See appendix A.) Activities in this area that can be performed by States and by non-Federal research agencies are not undertaken by the Public Health Service.

Research grants from the Public Health Service support a substantial volume of work in radiology by non-Federal investigators which can be done most

effectively by non-Federal scientists. This work is coordinated through the Medical Science Exchange of the National Research Council.

II. RADIOLOGICAL WORK IN THE NATIONAL INSTITUTES OF HEALTH

1. National Cancer Institute

This laboratory conducts fundamental studies relating to the way that radiation affects animals, animal organs, and biological systems. The work is undertaken basically because radiation both causes and cures cancer. The implications of a portion of these investigations are considered to be of such significance to problems faced by the Atomic Energy Commission that this agency has helped to support the studies.

2. National Institute of Arthritis and Metabolic Diseases

A major current line of research in this laboratory, which is supported in part by the Armed Forces special-weapons project because of the urgent practical implications of the findings, relates to susceptibility to infection following exposure to radiation. The defenses of animals and humans against infection are markedly decreased after heavy radiation doses. Many persons who would otherwise recover from radiation sustained as the result of an atomic-bomb explosion would die of infections. Just why and how radiation weakens the normal body defenses is not known. This laboratory is a major center in the Nation for study of this important problem.

Another area of study bears upon the effect of high X-ray doses upon the central nervous system. The manner in which X-rays affect nerve tissue, and particularly the operation of the central nervous system through direct or indirect effects, is imperfectly understood. There is some evidence that the disruption of enzyme systems under irradiation may be one of the keys to the problem.

This laboratory also conducts studies upon the effects of radiation upon proteins, a problem of such fundamental importance that a collaborating network of laboratories throughout the Nation is pursuing parts of this area of study.

3. General comment upon the basic research program in radiation at NIH

These studies do not include areas covered adequately by other governmental and nongovernmental laboratories. For example, the important role of radiation in genetics is covered by other research centers, and there is no program at NIH in this field. As another example, NIH studies do not cover the effects of extremely high energy radiation. A proposed program in this area has been indefinitely postponed because the expensive generators required for work in this area are found elsewhere.

Second, the total trained personnel and facilities in all the medical and biological laboratories of the country are not adequate to explore the biological effects of radiation with the speed and comprehensiveness dictated by the international situation.

Third, the prospective clinical studies to be undertaken in the radiation field will complement rather than duplicate investigations in this area undertaken by the Atomic Energy Commission.

Fourth, studies in the radiation field which scientific advisors to the Public Health Service recognize as being most urgent, and which are most effectively carried forward by outstanding scientists in universities and medical schools are supported—to the extent permitted by available appropriations—through research grants.

III. RADIOLOGICAL WORK IN THE BUREAU OF STATE SERVICES

In the field of radiological health the activities of the Bureau of State Services are covered in one appropriation, "Engineering, sanitation, and industrial hygiene, Public Health Service." These activities are aimed at developing knowledge in the techniques necessary for the State and local health departments of the Nation to meet the impact on health of the emerging atomic age. Efforts are in four specific areas:

1. To aid in increasing the level of knowledge and understanding of State and local health authorities, including the training of their personnel. Broader development and increasing uses of radiation-producing machinery and radioactive materials will impose additional responsibilities on the States.

2. At the request of the Association of State and Territorial Health Officers and the Atomic Energy Commission, the Bureau serves as a means of providing information to the States as rapidly as it becomes available for public use.

3. Field investigations carried out cooperatively with the Atomic Energy Commission have three objectives:

(*a*) To develop practical methods of handling and disposing of radioactive waste. This work is underway at the Los Alamos installation.

(*b*) To study the behavior of radioactive waste in natural water. This work attempts to establish an understanding of the behavior and mechanics of dilution and dispersion of radioactive substances discharged to waterways. This operation is underway at the Hanford works on the Columbia River and at the Savannah River project in South Carolina.

(*c*) Studies being carried out at the Oak Ridge National Laboratory are aimed at determining the efficiency of current water treatment methods in removing radioactive materials from water. Included in this work are studies to improve methods of detecting radioactivity in water.

4. At the request of, and in cooperation with State health authorities, the Bureau of State Services is developing and demonstrating the necessary field techniques required for public health protection in specific areas.

Coordination of Public Health Service Radiological Work With Related Work in Other Federal Agencies

There is a close official and personal relationship between the key Public Health Service staff engaged in radiological work and the staffs of other Federal agencies involved in related activities. These relationships change as problems change in this rapidly evolving field. The recent compilation of working arrangements noted below is adequate to show how coordination is achieved in this field:

ARMED FORCES SPECIAL WEAPONS PROJECT

The chief of the Nuclear Radiation Biology Section (NIH) is a director of a large scientific program at the atomic weapons tests. AFSWP has provided funds to his laboratory for urgently needed studies which the laboratory is particularly competent to undertake.

ARGONNE LABORATORY (AEC)

The Chief of the Laboratory of Biophysics (NIH) has close working relationships with the scientific personnel of this laboratory.

TEST PLANNING AND SCREENING COMMITTEE OF AEC

This Committee reviews all tests conducted in connection with atomic bomb test explosions. The Public Health Service has a member on the Committee. He participates in committee deliberations. He also informs Public Health staff who are cleared and who have legitimate scientific interests of proposed tests and transmits to the Committee tests desired by Public Health Service scientists.

NAVAL RADIATION DEFENSE LABORATORY

Public Health Service has a liaison officer at this laboratory.

RADIATION COMMITTEE OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

AEC officials in charge of radio-isotope distribution urgently need better organizations within States to aid them in policing the use of isotopes to avoid hazardous exposure. The Public Health Service is the link between AEC and the States through this Radiation Committee.

AEC CONTRACTORS

Contractors at several AEC installations are cooperating in stream pollution studies.

NATIONAL COMMITTEE FOR RADIATION PROTECTION (BUREAU OF STANDARDS)

Public Health Service staff members serve on the parent committee, and on the subcommittees for monitoring methods and instruments, and waste disposal.

MEDICAL SCIENCES COMMITTEE OF THE RESEARCH AND DEVELOPMENT BOARD OF THE DEPARTMENT OF DEFENSE (PANEL ON MEDICAL ASPECTS OF ATOMIC WARFARE)

Two Public Health Service staff members are nonvoting members of this panel, a status which permits them to observe the Department of Defense activities and help coordinate work through exchange of information.

NATIONAL RESEARCH COUNCIL COMMITTEE

The National Research Council is the chartered private organization charged by executive order with the responsibility for advising Federal agencies on scientific matters. Public Health Service staff members serve on the following committees with interests in various areas of radiation: Cataract Committee, Committee on Radiology; Glossary Committee for Nuclear Science and Technology.

TECHNICAL ADVISORY BOARD FOR RESEARCH ON DECONTAMINATION OF RADIOACTIVE WATERS

Representatives of the Public Health Service, the Department of Defense, and the Atomic Energy Commission have been brought together in an advisory board to evaluate research being carried on jointly by the Public Health Service and the Atomic Energy Commission on the decontamination of radioactive water supplies.

With this array of coordinating groups, plus the desire of NIH to avoid duplication, plus the inherent self-interest of scientists in avoiding ground that has already been explored, the Public Health Service feels that the possibility of unwarranted and unknowing duplication of work is remote. Some duplication in research is not waste, but necessary checking on methods and findings. This sort of duplication, which is common to science, is left to the discretion of responsible scientists.

The radiological work conducted in the two bureaus of the Public Health Service is coordinated formally through the Service-wide Research Planning Council and informally through extensive personal staff contacts.

EXPENDITURES FOR CANCER RESEARCH IN UNITED STATES

Mr. BUSBEY. Dr. Heller, what is your best estimate of the total amount now being spent annually for cancer research in the United States from all sources?

Dr. HELLER. For cancer research as such?

Mr. BUSBEY. Yes.

Dr. HELLER. Not having the amount of money that is spent for cancer research in the several institutions throughout the world our best estimate is about $30 million. That includes activities of the National Cancer Institute, the American Cancer Society, and all of the voluntary agencies, like the Damon Runyon and others, in broadly interpreting cancer research including clinical investigation.

FOREIGN GRANTS

Mr. BUSBEY. Do you made any grants or spend any of these funds in any way outside the United States?

Dr. HELLER. There are a few grants made to foreign nationals in England, France, and one or two other countries. As a rule, they are made to men who are outstanding in the world, who are unique in that they and they alone perhaps only can do the research, or the geographic advantage of their location is such that it can only be done at these places.

Mr. BUSBEY. Approximately how much will such grants total?

Dr. HELLER. That amounts to $99,000 in active grants at present.

RECENT RESEARCH ACCOMPLISHMENTS

Mr. FOGARTY. Dr. Heller, according to your statement, there has been some progress in the past year due to research in cancer.

Dr. HELLER. Yes, sir.

Mr. FOGARTY. What are some of the developments of the past year?

Dr. HELLER. I think some of the most intriguing and some of the most spectacular things that have been done have been done in the area of chemical therapy. While still, as previously pointed out, they do not effect cures in any sense as we usually know cures, they have been of such sufficient interest and significance in the prolongation of life that the attention of scientists and research people generally has been stimulated—the prolongation of Hodgkin's disease, which is usually considered cancer, through the use of chemical agents like triethylene melamine and nitrogen mustard and the continued treatment of acute leukemia in children by compounds called anti-folic drugs.

TREATMENT OF LEUKEMIA

Mr. FOGARTY. Tell us something about that. A few years ago there was nothing with which to treat a child with leukemia; was there?

Dr. HELLER. Except the use of radiation. The use of radiation in acute leukemia previously has been the only weapon available, and soon the youngster reached a point at which radiation accomplished little or nothing. At that point there was nothing that could be done for the child except simply to keep him comfortable. By the use of these so-called antifolic drugs, most of the work on which has been done at the Boston Children's Hospital——

Mr. FOGARTY. Dr. Sydney Farber has been active in that field; has he not?

Dr. HELLER. Yes. Dr. Farber has been one of the pioneers and one of the outstanding figures. He has a world famous clinic. He treats patients from all over New England and other parts of the country who come there with leukemia. He has had more success in the management of these patients than any other clinic in the country, primarily, in my judgment, because he treats the individual as a total entity and does not simply treat the disease. He treats patients by the use of psychiatry and uses supporting treatment of transfusions or anything else that seems effective. He has one patient now who started with acute leukemia in 1949 whom he treated with anti-folic drugs and who is still alive—which is remarkable. In fact, that is phenomenal in the history of the management of leukemia.

I think that page is a bright one. Still it is true that no one has been cured yet. It may well be we are on the right track, and investigators like Dr. Farber and like our own group will be able to produce longer and longer remissions and produce better and better drugs as time goes on and our skills and our opportunities increase.

DIAGNOSTIC IMPROVEMENTS

Mr. FOGARTY. What, if anything, have been the developments in the diagnosis of cancer?

Dr. HELLER. Since the cutting off of a piece of tissue called biopsy has been primarily the stand-by for the diagnosis of cancer and still

is the basis for the diagnosis of cancer, there have been many attempts to effect short cuts or maybe improve the diagnosis of cancer. In the literature there are found something of the order of 1,200 cancer tests which, in medical circles, means there is no one single cancer test. By that I refer to the cytologic or chemical, urine or body fluid tests.

Several years ago Dr. Papaniolaou and Dr. Traut at the Cornell medical center developed a procedure which is called cytologic examination of body fluids. It is based primarily on the fact that cancer, particularly internal cancer—that is, cancer of the cervix, of the uterus, and prostate and other parts of the body—tend to shed cells depending upon the state of the lesion or the age of the lesion. An examination of those cells under some similar procedure to that for biopsy reveals that it is possible to produce a high percentage of recognition where cancer exists and so diagnose cancer and establish it early. Since we know the treatment of cancer early is important, early diagnosis means a more hopeful outlook for the patient, because we can apply surgery and radiation procedures. This, then, has resulted actually in the saving of life. That is, I think, the most promising and heartening advance that has been made in the diagnosis of cancer.

Now, there are some tests which are of extreme interest, which are similar to blood tests, with which you may be familiar. There is one in California in which we are very interested and for which support has been given during the last few years which looks to have considerable promise as a test which might be applied to masses of people and screen them for cancer. Only time will tell. Experts are very hopeful. We have a cooperative project with the University of California at Los Angeles in providing financial support. In addition, the University of Tennessee, the University of Kansas, and the University of Washington scientists are working on that test as well. So the test is a nationwide project. On this test, which seems to be the best test, there are efforts to establish its place, if it has one, and as quickly as possible makes it available to private physicians, hospitals, and other interested people in cancer control throughout the country. I hope we can report next year that test has become a really effective one to control cancer. Only time will tell.

DISSEMINATION OF RESEARCH RESULTS TO GENERAL PRACTITIONERS

Mr. FOGARTY. If that test does become a really effective test, how will you get that information to the general practitioner?

Dr. HELLER. Through our control program. We have the mechanics set up in the National Cancer Institute by which we work through the State health departments and through the medical schools and through private practitioners, with which we have a very close liaison. We have the facilities quickly to demonstrate, in collaboration with the States or medical schools, on a field basis, the feasibility, desirability or practicability of a test. We have had considerable experience in other parts of the Public Health Service in this approach.

Mr. FOGARTY. Just as an example, take this particular test and assume it becomes a true test next year; what steps will you take to get it to the practitioner?

Dr. HELLER. After it has been established, if it is established, that it is a true test, with a reasonable cost and easy of application and interpretation, we would get together with the State or city or some area or group of people in whom testing can be easily carried out. For instance, at Memphis, Tenn., there would be enough in matters of thousands of people to statistically determine if this was a significant test. In this instance, blood samples would be taken. They would be read by competent persons, and there would then be series of patients who had cancer in varying stages and a series of patients who did not have cancer, so far as medical means could ascertain. We then would be in a position to correlate the findings of those who had cancer against those who did not have cancer and establish the feasibility of the test as a mass-screening device.

IMPROVEMENTS IN X-RAY TREATMENT

Mr. FOGARTY. There have been some better X-ray machines developed in the past year, have there not? Was not some machine developed in a hospital in Boston recently that holds some promise?

Dr. HELLER. Yes, Mr. Fogarty. There have been a number of developments. One of the most interesting has been the so-called image amplification in the fluoroscopic examination of patients. The most of that work was done at Johns Hopkins as the result of a grant from the National Cancer Institute and still other important work done at the University of Chicago with similar support. Then, to provide a better technical advance so that the physician can keep the patient under observation or under physical view through the fluoroscope with a better image vision than previously existed, it has been possible to give the patient only about one-tenth as much radiation under the fluoroscope as would exist in the ordinary examination, and yet get a better image—something of the order of 10 to 100 times better, depending upon the machine.

At Hopkins there was developed also an X-ray machine which routinely could be used in an economical fashion to determine whether or not gastric cancer existed through the visualization of the stomach with a barium mixture which outlines the stomach, since it is opaque to the X-ray. It was found feasible and possible at Hopkins to find gastric cancer which occurs about 1 in every 900 times in women and about 1 in 800 times in men with this machine. We believe gastric cancer was being picked up as it did occur.

These are two notable advances in the diagnosis of cancer. There have been other advances. You mentioned Boston. I presume that is the work of the Massachusetts Institute of Technology, developed by Dr. Hare and Dr. Trump. Dr. Hare is a member of the Lahey clinic; Dr. Trump is with the Massachusetts Institute of Technology clinic, in which there was a rotation of the patient so that the X-ray beam of 2 million volts impinged at all times immediately or exactly upon the lesion with a pin-pointing of the beam so that the cancer and only the cancer was destroyed and other tissues were not harmed appreciably. That is a new advance in the management of a patient with cancer and has been, in the view of many radiologists, a significant advance in the management of cancer patients.

INCIDENCE OF LUNG CANCER

Mr. FOGARTY. Doctor, what about lung cancer in men? Is that on the increase?

Dr. HELLER. It is reported to be on the increase. Our data would support that, Mr. Fogarty.

In the last 25 or 30 years it has jumped up severalfold in men. There has not been a similar increase in the occurrence of lung cancer in women. Why this should be is not completely known.

As you are well aware, the correlation of heavy cigarette smoking has been mentioned in connection with the occurrence of lung cancer, but this has not, to our satisfaction, definitely been established despite the fact that there is a very high correlation between heavy cigarette smoking and the occurrence of lung cancer. Our epidemiologists and scientists seem to feel that there are some additional factors which we have not yet discovered or studied sufficiently, which may have a bearing on this particular problem.

Mr. FOGARTY. There are some women who are pretty heavy cigarette smokers. Has it developed in the case of women who are pretty heavy cigarette smokers?

Dr. HELLER. Not to the same extent as for the men.

As a matter of fact, there is no correlation, to my knowledge, between heavy cigarette smoking in the women and the occurrence of lung cancer. There may be a sex factor in this, Mr. Fogarty. It seems reasonable, because certainly women have been smoking for a sufficiently long time and have been heavy smokers, and there has been time for the same phenomenon to be observed in them as has been observed in the men.

But the data, both here and abroad, would indicate a similar situation throughout the world in which cancer of the lung in men seems to be on the increase, and in men only.

Mr. FOGARTY. We were told a year ago of the work being done by Dr. Huggins in Chicago.

Dr. HELLER. Yes, sir.

Mr. FOGARTY. On removal of the adrenal glands. How has that progressed?

Dr. HELLER. Yes, sir. Dr. Huggins has been one of the pioneers in the study of cancer in the hormone area generally. It was he who first demonstrated successfully that castration of a male and of a female would produce beneficial effects in cancer of the prostate and cancer of the breast.

Some of these patients were well for a year or so, and then went on to die from cancer. He reasoned that certain other glands of the body were pouring into the system a hormonal secretion which was conducive to the growth of cancer. Accordingly he removed both adrenal glands, which are small glands located just above the kidneys.

He has been successful in about half of his cases, he told me, in that he has produced remarkable remissions in cancer. I will not say cures, because not long enough observation has elapsed. Some of them have not succeeded. Why, he does not know.

I was informed recently that in cancer of the breast he was more encouraged than in cancer of the prostate, whereas previously the cancer of the prostate was the one in which most encouraging results had been noted.

USE OF CORTISONE

This necessitates complete removal, bilateral removal. Each gland is removed. Since the body has to get the elements which these glands secrete, the use of cortisone, about 50 milligrams a day, will keep that person in equilibrium. Only through the advent of cortisone has it been possible for this particular operation to be successful.

That is another example of the interaction of everything we find, in whatever field of medical research, and its impact on other fields. Cortisone was not suspected to play a great role in cancer management. It has turned out in this particular instance to be very significant. In fact, the patient would die without such supportive treatment.

Again, Mr. Fogarty, time will tell as to whether or not this total adrenalectomy will be the treatment of choice in the management of far-advanced breast and prostate cancers. It is a very radical operation, and in fact, a dangerous operation, but in the hands of good people like Dr. Huggins and the other medical centers of the country—and it is being done in other medical centers, I might say—it has as favorable a mortality rate, if we can phrase it that way, as most any operation.

RESEARCH FELLOWSHIP PROGRAM

Mr. FOGARTY. Doctor, in your statement you said that in the fellowship program 790 young men and women have been supported in their training to become research scientists. What do you mean by that?

Dr. HELLER. Those, Mr. Fogarty, are young men and women, about 50 percent of whom are physicians, and the others are persons who are engaged in pursuit of a scientific discipline. It may be genetics, physics, chemistry, or what have you. Those are persons who have been enabled to enter the medical research field, or the research field, primarily in the medical research field, through support in their post-doctorate studies. They have been able to go to institutions in which good research is being done, to participate in research and to learn methods, to get the ideas and to be able to extract the good things in this institution or that institution. They come to a maturity which enables them to go out on their own to other institutions and to become independent investigators in cancer, heart, arthritis, or metabolic diseases, or other important areas of medical research.

Mr. FOGARTY. You say about 50 percent of these were physicians?

Dr. HELLER. Yes, sir. It varies up and down, but about 50 percent of them are physicians.

Mr. FOGARTY. Have you any idea how many of that 50 percent were in private practice at the time they received this training?

Dr. HELLER. Mr. Fogarty, I cannot give you that exact figure. As a rule these younger men come directly from their residences or their internships and are interested in research and do not go into private practice. However, there may be a few who come from private practice and who have acquired an interest in research. This percentage is negligible.

PROPORTION OF RESEARCH FELLOWS WHO SUBSEQUENTLY ENTER PRIVATE PRACTICE

Mr. FOGARTY. The question arose here yesterday as to the advisability of giving this training to a private physician who, after he gets the training, might go back into his own practice. He is getting the benefit of this training, and using it for his own financial gain.

Dr. HELLER. Mr. Fogarty, there are two programs here. One is the fellowship program and the other is the traineeship program. The 790 is the research fellowship program.

Mr. FOGARTY. Do they generally stay in the research field?

Dr. HELLER. Yes, sir; almost all of them, Mr. Fogarty, remain in the research field or in the teaching field. This has been a quite satisfactory program.

As I indicated previously, about three-fourths of the fellows have been in the so-called postdoctorate area. That is those who already have their doctorate and simply go to research institutions and medical schools and acquire the skills and knowledge of methods and day-by-day contact with the leaders in research.

SPECIALIZED TRAINING PROGRAM

Mr. FOGARTY. How about the 451 young physicians who have received specialized training in surgery, medicine, and so forth?

Dr. HELLER. Yes, sir. That is 451 since the inception of the program, Mr. Fogarty, which began in 1938.

At this time there are 139 such individuals receiving support. These are young men and women, all physicians, who manifest an interest in cancer and on a competitive basis go to the institution of choice throughout the country and perfect themselves in surgery, radiology, pathology, medicine, and some of the other specialties such as gynocology. These young people acquire proficiency in the management of cancer and go back to their communities.

In about 92 percent of the cases that we have studied thus far—and we are now undertaking another study—they have remained in the cancer field; either in cancer diagnostic clinics or in a medical school affiliated with cancer-control activities. The remaining 8 percent, who have not remained in direct cancer activities or in activities which are definitely referable to cancer, nevertheless have been instructed and have a knowledge of the problem of improved management of cancer, to the extent that when they go back to private practice the management and control of cancer is enhanced a great deal by their training.

We know that the mortality rate has been lowered because of their increased skill and proficiency. There simply are not enough people who know properly how to handle cancer patients. A good surgeon certainly can do a good job, and a man should be a good surgeon or a good internist or a good pathologist or a good radiologist; but certainly in our judgment the special training superimposed upon this excellent background of medicine and surgery is such that he is an immeasurably more valuable man to the community and particularly to his medical school. They have been the persons whom we have used as coordinators of cancer teaching, as directors of diagnostic clinics, as directors of detection clinics, and other similar activities.

The majority of those men have become affiliated with the American Cancer Society activities back in their respective States and have been of great value.

As an example, our present Associate Director in charge of research in the National Cancer Institute received his training through a fellowship of the National Cancer Institute. Subsequently he went to

several other institutions and emerged as a very proficient and able cancer investigator.

We were successful in getting him to join us last July. Now he is Director of Research at the National Cancer Institute, a very able and very successful man, whose training and whose direction toward cancer research and clinical investigation came about through this particular program of which we are speaking.

TEACHING GRANT PROGRAM

Mr. FOGARTY. Tell us something about your teaching grants to the medical schools.

Dr. HELLER. Yes, sir.

Mr. FOGARTY. How many schools are there? What are the schools which get the grants? How much do they get? What do they accomplish?

Dr. HELLER. Yes, sir. The grants to schools number 79, which embraces all of the 4-year medical schools. That takes in six schools of osteopathy as well. There are 79 schools participating in this program. There is a maximum grant of $25,000 to each of these 4-year medical schools. The grant is awarded upon the recommendations of the National Advisory Cancer Council to the Surgeon General.

In order for a school to be awarded this grant it means submitting a plan and a suitable budget. This is for the improvement of the teaching of cancer in this medical school, and is designed to acquaint the medical student through all 4 years with the elements that we know as modern management of cancer.

In addition to these 79 medical schools, grants of $5,000 each are made to the 42 dental schools which comprise all of the dental schools in the country; and to the eight 2-year medical schools in the country; a total of 48 receiving $5,000 each.

Again, since dentists see for the first time, as a rule, lesions which occur in the mouth—and these comprise about 11 percent of cancers—it is felt this is an important area in which we as practical cancer control people should direct our interest. Therefore, this modest sum of $5,000 is accomplishing much in the improvement of the recognition of cancer.

When a dentist sees a cancer in the oral cavity, as a rule he refers it to a physician for diagnosis and management. These grants, in our opinion, Mr. Fogarty, have been successful. The knowledge of cancer is measurable.

A test has been developed at the University of California which now has been applied to about three-fifths of the medical schools in the country. Year after year they are given certain test items which are psychologically devised so that we have every reason to believe that the measurement of the knowledge of the increase of knowledge of the student is valid. In all medical schools in which this program obtains there is a demonstrable improvement in the amount of knowledge which the medical student gets and which he retains. Therefore, when he graduates, the other programs which are operated by the National Cancer Institute and the American Cancer Society are available to him. He is thereby allowed or is in a position to be kept acquainted with the modern advances in management of cancer and the proper diagnostic and therapeutic procedures.

EXTENT OF FEDERAL CONTROL

Mr. FOGARTY. Is there any Federal control in these programs?

Dr. HELLER. No, sir. The only Federal control, if we choose to use that word, is, of course, the usual auditing procedures which are necessary in any Federal grant.

Mr. FOGARTY. To see to it that this fund is expended for the purpose we want it expended?

Dr. HELLER. That is correct, sir. We were first to admit that we did not know what constituted a good cancer teaching program in a medical school. Only the schools themselves could arrive at that.

On their own, voluntarily, they got together a group which at present is studying what constitutes good cancer teaching, and there will emerge in the near future, we hope, a so-called model program, which is their program and not a Federal program. This is their own program, which they elaborate which if not an ideal program is still one that will operate in a medical school to good advantage.

EFFECT OF FEDERAL PROGRAM ON VOLUNTARY AGENCIES

Mr. FOGARTY. Now, when the Federal Government began appropriating funds for research on cancer, heart, and other health activities a few years ago, there was some concern expressed by people connected with the voluntary agencies that the Federal program might hurt their fund-raising campaigns. That has not turned out to be so, has it?

Dr. HELLER. No, sir. On the contrary, there has been a steady and gradual increase in the amount of funds which the American Cancer Society has obtained from the public.

The $16 million some figure mentioned previously—as a matter of fact, it was slightly better, I believe, than $16 million—has been the highest amount of funds obtained. There is every reason to believe on the part of the American Cancer Society people that they can set their goal higher than that.

Similarly, the Damon Runyon Fund and certain other voluntary activities have experienced some increases in the amounts of money which the public has contributed.

APPROPRIATIONS

Mr. FOGARTY. Now, the Senate increased this appropriation a year ago, did it not, over the amount included in the House bill?

Dr. HELLER. Yes, sir.

Mr. FOGARTY. By how much?

Dr. HELLER. $2,637,000.

Mr. FOGARTY. There have been in the past few years bills introduced in both the House and the Senate which called for tremendous amounts of money to be appropriated, have there not?

Dr. HELLER. Yes, sir.

Mr. FOGARTY. How much did some of those bills amount to?

Dr. HELLER. One which has been introduced in both the Senate and House fairly often has been for $100 million, to be used until expended. This has received considerable attention and has been the subject of much conversation.

1954 BUDGET INCREASES

Mr. FOGARTY. In your appropriation request this year you show an increase of $4,480,000. Of that increase, you have one item of $4 million for the construction of research facilities. We have been told that that item will not be included in the revised budget, so your increase will be only $480,000 instead of $4,480,000.

Dr. HELLER. That is correct, sir.

Mr. FOGARTY. And that increase is under direct operations in research?

Dr. HELLER. Yes, sir.

Mr. FOGARTY. You show an increase there of $659,000, and at the same time you show a decrease in positions of 7. How do you account for that, and for what is the $659,000?

CLINICAL CENTER OPERATIONS

Dr. HELLER. That $659,000, Mr. Fogarty, is primarily for the clinical-center operations, as you have indicated. We have found that we can get along with 7 fewer positions than previously we did have.

Mr. FOGARTY. This $600,000 is going into the new clinical center?

Dr. HELLER. Yes, sir.

Mr. FOGARTY. For what?

Dr. HELLER. For our portion of the support of the bed-care patients, for the provision of clinicians to look after the patients; and for supplies, equipment, et cetera.

Mr. FOGARTY. I see. It is because of the opening of the new clinical center that this increase is shown?

Dr. HELLER. Yes, sir.

RELATIONSHIP OF FEDERAL AND VOLUNTARY ORGANIZATIONS

Mr. FERNANDEZ. Doctor, you said the American Cancer Society, the major voluntary organization in the cancer field, has worked very closely with the National Cancer Institute on all phases of the program. Would you mind enlarging a little on that, Doctor?

Dr. HELLER. I would be happy to, Mr. Fernandez. The American Cancer Society has State divisions throughout the entire Nation, and in fact in Puerto Rico and Hawaii. It operates somewhat like the State health departments in the sense that each State organization is an entity organizationally and fingers out to the various localities, to the smaller subdivisions, so that each city and frequently county will have a chapter in which interested men and women, which includes professional as well as lay persons, engage in cancer activities.

Their drive starts April 1, which is the traditional month. They work very closely with the official agencies. The problem is so great and there is so much that needs to be done that there is room enough for a number of people and agencies in the field without there being competition or petty jealousies. Now, they do exist occasionally, since human beings sometimes seem to be unable to get along in the same activity. But the pace or the tone is set by the national organization, the headquarters of which is in New York. The National Cancer Institute and the American Cancer Society work very closely together. We keep them apprized of what we are doing programwise. They in turn keep us informed of their activities.

I am a director of the American Cancer Society. Certain of their key people serve on our boards and advise us. We work closely with the committee on growth, which is the unit they use of the National Research Council to recommend approval of research grants. It corresponds to our National Advisory Cancer Council.

This has been a very happy working relationship, Mr. Fernandez, and I think a very profitable one, in which we have been able to do a better job together than attempting to go our separate ways. Yet at the same time we maintain our organizational entity. We undertake programs on our own and we just simply keep each other informed closely and work closely together.

Mr. FERNANDEZ. Do you use any funds in connection with them, or give payments to them or through them?

Dr. HELLER. Only in a collaborative sense, Mr. Fernandez. For instance, if we make a film there is a grant, let us say, of $10,000 or $15,000 to the American Cancer Society as our part of making the film.

We have made a very successful film, for instance, designed for women, to persuade them to examine their own breasts once a month for the appearance or absence of cancer. That film has been a joint activity and an extremely successful one inasmuch as it can be distributed both through our resources and through their resources. It is cheaper since we do make it collaboratively.

Mr. FERNANDEZ. Thank you, Doctor. That is all, Mr. Chairman.

Mr. BUSBEY. Thank you, Dr. Heller. Your institute is working in what I would think would be a very exciting field. These young people who are attracted into this research program certainly are not only having a wonderful opportunity, but I think they must appreciate also that they are working in a very exciting field.

Dr. HELLER. They do, Mr. Chairman.

Mr. BUSBEY. Thank you very much.

Dr. HELLER. Thank you, sir, and gentlemen.

TUESDAY, MARCH 31, 1953.

MENTAL HEALTH ACTIVITIES

WITNESS

DR. ROBERT H. FELIX, DIRECTOR

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$9,988,737	$10,895,000	$15,500,000
Reimbursements from non-Federal sources	18,320	20,200	19,500
Total available for obligation	10,007,057	10,915,200	15,519,500
Unobligated balance, estimated savings	−106,466		
Obligations incurred	9,900,591	10,915,200	15,519,500
Comparative transfer to—			
"Neurology and blindness activities, Public Health Service"	−69,552	−74,000	
"Salaries and expenses, Office of the General Counsel, Office of the Administrator, Federal Security Agency"		−2,000	
Total obligations	9,831,039	10,839,200	15,519,500

NOTE.—Reimbursements from non-Federal sources above are for personnel detailed to the Juvenile Court, District of Columbia, in accordance with provision of the District of Columbia Appropriation Act; and from the proceeds of sale of personal property (40 U. S. C. 481 (c)).

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
1. Grants:			
(a) Grants for research and training:			
(1) Research projects	[1] $1,637,475	[1] $1,649,022	$2,665,000
(2) Research fellowships	255,084	250,000	187,000
(3) Training grants	[1] 3,958,157	3,676,000	4,176,000
(4) Construction of research facilities			2,500,000
(b) Grants for detection, diagnosis, and other preventive and control services	3,008,958	3,100,000	3,100,000
2. Direct operations:			
(a) Research	845,399	1,295,300	1,990,000
(b) Other direct operations:			
(1) Review and approval of research and training grants	123,119	130,000	130,000
(2) Training activities	70,552	70,000	70,000
(3) Technical assistance to States	443,921	418,200	417,500
(4) Administration	295,989	314,700	284,000
Total funds for program performance	10,638,654	10,903,222	15,519,500
Adjustment for obligations incurred in advance of program performance	[1] −807,615	[1] − 64,022	
Total obligations	9,831,039	10,839,200	15,519,500

[1] Some of the obligations for grants for research projects and training were incurred several years in advance of actual program performance. By means of the adjustment line shown in this schedule, the amounts by activity reflect the actual performance levels for each year.

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Total number of permanent positions	242	260	282
Full-time equivalent of all other positions	9	11	12
Average number of all employees	204	239	275
Average salaries and grades:			
General schedule grades:			
Average salary	$4,708	$4,999	$5,038
Average grade	GS–6.7	GS–7.2	GS–7.3
01 Personal services:			
Permanent positions	$1,069,826	$1,308,549	$1,498,284
Part-time and temporary positions	40,339	38,570	41,500
Regular pay in excess of 52-week base	2,530	4,007	4,442
Payment above basic rates	4,006	6,500	7,600
Total personal services	1,116,701	1,357,626	1,551,826
02 Travel	96,859	95,000	105,000
03 Transportation of things	11,159	6,500	8,600
04 Communication services	9,430	10,300	11,800
05 Rents and utility services	164	500	500
06 Printing and reproduction	36,966	26,600	31,600
07 Other contractual services	18,971	41,500	32,500
Reimbursements to "Operating expenses, National Institutes of Health, Public Health Service"	321,612	622,400	1,045,800
08 Supplies and materials	82,262	51,800	68,000
09 Equipment	86,126	17,900	36,900
11 Grants, subsidies, and contributions	8,052,059	8,611,000	12,628,000
13 Refunds, awards, and indemnities	20		
15 Taxes and assessments	3,137	3,000	3,900
Subtotal	9,835,460	10,844,126	15,524,426
Deduct charges for quarters and subsistence	4,421	4,926	4,926
Total obligations	9,831,039	10,839,200	15,519,500

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$1,348,408	$827,081	$922,081
Obligations incurred during the year	9,900,591	10,915,200	15,519,500
	11,248,999	11,742,281	16,441,581
Deduct:			
Reimbursable obligations	18,320	20,200	19,500
Adjustment in obligations of prior years	459,022		
Unliquidated obligations, end of year	827,081	922,081	4,322,081
Obligations transferred to "Mental health activities (liquidation of contract authorization), Public Health Service"	494,922		
Obligated balance carried to certified claims account	5,423		
Total expenditures	9,444,231	10,800,000	12,100,000
Expenditures are distributed as follows:			
Out of current authorizations	9,111,159	10,450,000	11,700,000
Out of prior authorizations	333,072	350,000	400,000

Amounts available for liquidation of contract authorization

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$573,000		
Applied to contract authorization	−494,922		
Prior year balance available		$78,078	$78,078
Balance available in subsequent year	−78,078	−78,078	
Carried to surplus			−78,078
Obligations incurred			

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$423,920	$66,299	
Obligations transferred from "Mental health activities, Public Health Service"	494,922		
	918,842	66,299	
Deduct unliquidated obligations, end of year	66,299		
Total expenditures	852,543	66,299	
Expenditures are distributed as follows:			
Out of appropriations to liquidate prior year contract authorizations	430,900		
Out of prior authorizations	421,643	66,299	

Mr. BUSBEY. The committee will come to order.

The next appropriation request we have for consideration today is that for "Mental health activities." Dr. Felix, we would be very pleased to hear your general statement at this time.

GENERAL STATEMENT

Dr. FELIX. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, mental illness and other emotional disorders constitute one of the most serious public-health problems confronting America today. The scope of the problem includes not only the mentally ill confined to institutions, but also many who are just as ill but are not hospitalized. It also includes the emotionally sick, the personality misfits, and many whose lives

have been sidetracked into the fields of alcoholism, drug addiction, juvenile delinquency, and crime. In a period of stresses and strains, involving anxiety about the future and the need to maintain a state of watchful preparedness, the soundness of the mental health of our citizens is a vital element in our national security.

There is abundant evidence that the state of America's mental health is a problem which deserves considerable concern. There are today more than 550,000 persons in mental hospitals.

I might say here, Mr. Chairman, that I have gotten this week the figures for 1951. The ones you have here are for the year previous. There are now 580,000 persons in long-care mental hospitals.

Additional tens of thousands are receiving psychiatric treatment from physicians in private practice and through clinics. It has been estimated that at least 6 percent of the population are suffering from emotional or other personality disturbances. It is, of course, virtually impossible to estimate the cost of these disorders in terms of nonproductivity, absenteeism, loss in efficiency, loss in tax revenues, and payments for public assistance.

Not only is the number of persons in mental hospitals high, but it is getting higher. Although the Nation's population has increased only 14 percent since 1939, there are 17 percent more persons in mental hospitals. Although the number of persons over 60 years of age has increased by 25 percent in the same period, the number of patients of this age group in mental hospitals has increased by 58 percent. Of all the hospital beds available for all kinds of illness, one-half are now occupied by the mentally ill.

The effect of mental and emotional illness on the national strength in terms of manpower for the Armed Forces became strikingly clear in World War II, and impelled Congress to take action. About 1,846,000 persons, or 38 percent of all rejections, were unacceptable because of neuropsychiatric disorders. Yet, in spite of this screening, about 387,000 more were medically discharged from the Army, and about 77,000 from the Navy for neuropsychiatric reasons. Another 163,000 Army and 92,000 Navy men and women were discharged administratively for personality disorders. Thus, a total of more than 2,500,000 men were lost to the Nation's armed services through mental and emotional diseases and defects. This amounted to enough men to constitute 177 Army infantry divisions. The loss represents an even greater figure than the total number of men the Army sent to the Pacific theater of operations during all of World War II.

NATIONAL MENTAL HEALTH ACT OF 1946

In 1946 Congress passed the National Mental Health Act, enabling the Public Health Service to organize a comprehensive attack on mental illness. The act provided for three principal means of carrying out this effort—research, training of mental-health personnel, and the development of community mental-health programs. To carry out these responsibilities, the National Institute of Mental Health was established as a part of the Public Health Service's National Institutes of Health, with headquarters in Bethesda, Md. A National Mental Health Advisory Council was established, too, composed of experts from pertinent professional fields and representatives of the general public. In making grants to support research and

training, the Council helps the Institute determine those investigators or institutions which should receive Federal funds. Distribution of grant-in-aid funds to the States for community mental-health programs is determined by a formula based on each State's population, economic need, and the extent of its mental-health problems.

INCREASING COSTS OF CARING FOR MENTALLY ILL

The actual expenditures on all of these programs—training, research, and State mental-health programs—are small compared to the staggering costs of mental illness, even in that segment of the problem represented by the operation of public mental hospitals and compensation to veterans suffering phychiatric disabilities. There is little hope of reducing these costs until greater progress has been made in controlling the gigantic problem of mental illness. In 1950 the cost of maintaining patients in mental institutions was $551 million of which $506 million was paid from public funds. In the same year another $186 million was spent on the construction of badly needed mental-health facilities. In addition the Veterans' Administration pays out almost $360 million each year to veterans suffering from neuropsychiatric disorders. Thus, the failure to reduce the burden of mental illness is costing the taxpayer approximately a billion dollars a year.

I would like to interject two notes here. First, this is increasing at the rate of about $100 million a year. Second, I have just received a forecast publication of the Veterans' Administration dated March 1, 1953. Their prediction is that by 1960 there will be 100,000 psychotic veterans eligible for hospitalization in their hospitals; either service or nonservice connected, but eligible under the law.

They will by 1960 be able to accommodate about 54,000, if they can staff that many hospitals. Unless the State hospitals can take a substantial number of this group there will be a waiting list of between 40,000 and 50,000 veterans alone by 1960. That means more trained people.

IMPROVEMENTS IN TREATMENT TECHNIQUES

On the other hand, the picture is not altogether dark. There is considerable evidence that funds expended in furthering research, in traning mental health personnel, and in expanding community preventive programs, can help reduce the cost of mental illness. Today, 2 out of every 5 patients admitted to a mental hospital for the first time will be discharged within a year. For schizophrenics, of those with dementia praecox, a group once considered practically hopeless, the odds for release back to the community are better than 50–50. A generation ago, involutional melancholia, an illness of middle age, was hopless in about 2 cases out of every 3. Today, because of improvements in treatment developed through research, about two-thirds of these patients are discharged within a year of their admission. Even the "hard core" of long-term patients in mental hospitals is often helped by intensive treatment. A study of this group at the Stockton State Hospital in California showed that intensive treatment, using methods developed through research, can triple the patient's chanches of getting out of the hospital. In Korea, where each Army division has a psychiatrist, assisted by battalion surgeons, two-thirds

of the breakdown cases are rehabilitated and returned to duty without leaving the division, and only 4 percent need to be returned to this country for treatment.

I might say this is a dramatic improvement over World War II, where 8 percent were evacuated to the Zone of Interior, and over World War I, where 15 percent were in that category. The reason is more and better trained psychiatrists in the service.

I might add one other thing, Mr. Chairman. Less than 10 percent of these psychiatric casualties are repeaters, that come back a second time. They go up and stay up.

Early treatment of patients in clinics often enables them to avoid the need for hospitalization. As communities increase their psychiatric services to schools, courts, health, welfare, and other community agencies, they in turn can provide more effective help to people who have emotional problems and help prevent these problems from becoming disabling disorders.

FEDERAL-TRAINING PROGRAM

However, if we are to speed up our progress against mental illness and make better treatment possible, we must train considerably more personnel than are now available. Under the provisions of the National Mental Health Act, the National Institute of Mental Health has been assisting training centers, medical schools, and individuals so that more persons can get the essential training needed. A portion of these Federal training funds go to undergraduate medical schools, enabling them to give medical students a better foundation in psychiatry and the emotional aspects of illness generally. It is imperative that more psychiatrists, clinical psychologists, psychiatric nurses, and psychiatric social workers be trained if we are to expand mental health clinics, provide better hospital care, and improve community preventive services.

In many mental institutions, there are patients who have improved to the degree that they are eligible for discharge, but who must remain in hospital custody because there are few suitable places in the community for them and not enough psychiatric social workers to help them find such a place. Many others remain because the hospital does not have enough psychiatrists, clinical psychologists, and psychiatric nurses to determine which patients are actually ready for discharge. Many more might be helped toward early discharge if there were sufficient staff to make use of the new, successful treatment techniques. Likewise, other persons might be helped before their condition becomes so serious as to require their hospitalization, if there were enough community clinics with adequate facilities and staff.

In the first 5 years in which training grants have been available, the National Institute of Mental Health has aided directly in specialized training by providing 838 stipends in psychiatry, 635 stipends in psychiatric nursing, 535 stipends in clinical psychology, and 884 stipends in psychiatric social work. In addition, it has aided 116 institutions in improving their teaching in the psychiatric specialties—I mean by this all of these various specialties—and it has helped 42 medical schools strengthen basic mental health instruction for 13,000 recently graduated physicians.

STATE ACTIVITIES

At the same time the States, with the aid of Federal grants-in-aid, are providing clinics and other preventive services so that many potential patients can be treated before hospitalization becomes necessary. Prior to the passage of the National Mental Health Act, only half of the 48 States had community mental-health programs; now all States have them. The number of mental-health clinics has grown in the past 5 years from about 850 to 1,150. Between 300 and 350 of these are assisted at any one time by Federal funds. Generally funds are used to enable a State to start new projects in its program which could not otherwise be initiated. As these take root, the States take over the financing. The National Institute of Mental Health, in addition to administering these grant-in-aid funds, provides consultative and technical help, enabling States to benefit from successful practices already tested and found useful in other parts of the country.

Because it will still be a long time before sufficient mental-health personnel are trained to fill needs within the States, it has proved valuable to conduct training conferences where members of related professions can acquire basic psychiatric orientation to help them deal with emotional problems in those people they serve, and to detect any early signs of mental illness. Grant-in-aid funds made it possible for the States to conduct 138 such conferences in fiscal year 1952, serving almost 13,000 professional persons, including physicians, teachers, ministers, health-department personnel, social workers, nurses, law-enforcement officials, and juvenile-court officers. In addition, the States are waging intensive educational campaigns in an effort to overcome the kinds of fears and superstitions which may prevent people from seeking needed psychiatric help, and which may deter employers or neighbors from giving discharged mental patients a fair chance for rehabilitation. The institute has served as a clearinghouse for factual information on progressive developments, helping provide the States and professional persons with appropriate material to be used in developing preventive programs.

REMAINING RESEARCH PROBLEMS

Clinics, hospitals, psychiatrists in private practice, health departments, and other community agencies are making use as well and as rapidly as they can of the new knowledge and improved techniques being developed, but there is still a need for greater research into the whole problem of mental illnesses. Medical knowledge about man's physical self has far outstripped knowledge of his mental functions and processes. Yet so closely interwoven are man's mental and physical functions that newly developed knowledge about human emotions is proving indispensable in the solution of many of man's problems hitherto believed to be purely physical in nature.

Studies in mental illness must include investigations of the microstructure of the brain and the nervous system; the role of the endocrine glands; the chemical aspects of body functions; the genetic factors involved; the phenomena of mental processes, normal and abnormal; and the influence of man's environment, from his earliest relationships within his family through his later ones with other members of his community. Research must probe into the causes, treatment, and pre-

vention not only of the many kinds of mental illnesses which plague mankind but also into other erratic forms of behavior which constitute a potential threat to the individual himself, as well as to his community: alcoholism, drug addiction, and those psychopathic tendencies which lead to juvenile delinquency and crime. These divergent forms of behavior constitute still another cost to the community—impossible to measure either in dollars or in personal and family grief and despair.

Psychosomatic medicine is another field in which more research is needed. Physicians in private practice report that 50 percent or more of the patients who come to their offices have complaints which involve emotional problems. We are only beginning to learn the connection between emotional stress and such common illnesses as heart disease, hypertension, arthritis, stomach ulcers, asthma, diabetes, and skin diseases. Even in such diseases as cancer and tuberculosis, emotional factors play a very significant role in the management of the case.

Among the mental disorders themselves, it has been estimated that if we could find a cure for the particular mental illness known as schizophrenia, we would be able to release half of the persons now in our mental institutions. But the search for a cure for schizophrenia, or any other mental disease, entails studies in many varied fields, since we feel certain that all possible hypotheses relating to cause and cure have not yet even been formulated, to say nothing of having been tested. When we are unsuccessful in following known leads, we must study new methods and establish new hypotheses. We must explore a wide area of basic research, as we can never be certain just where and how we will uncover information which will lead to promising new discoveries.

GRANTS FOR RESEARCH PROJECTS AND FELLOWSHIPS

Under the provisions of the National Mental Health Act, the Institute was given the responsibility for administering a Federal research grant program to assist scientists in universities, hospitals, and other research laboratories. During the first 5 years in which this program operated, grants were made to 165 research projects conducted by about 650 scientists. In addition, research fellowships were made available to some 150 individual scientists so that they might receive training to improve their skills in their chosen fields of research. From these scientists has come new information, shedding additional light on the functioning of intact and damaged nervous systems, on the nature and causes of serious mental disorder, on the evaluation of preventive and treatment techniques in mental disease, and on the relationship of childhood maladjustment to adult mental illness.

The Institute itself has not yet developed a comprehensive research program in its own laboratories. In only three fields has substantial work been carried out—drug addiction, neurophysiology, and environmental studies. With the opening of the Public Health Service Clinical Center, facilities will be available for expanding laboratory research and engaging in clinical studies.

I thought, Mr. Chairman, you might be interested in seeing one instrument which has been developed in our laboratory by a scientist who was trained in our program.

That, Mr. Chairman [indicating], is what is known as a microelectrode.

Mr. BUSBEY. It looks like a test tube.

Dr. FELIX. It is the little glass tube inside, Mr. Chairman. You may think you see the tip of that, but I can assure you you cannot. The tip cannot be seen with the highest power light microscope. The tip is about four one-millionths of an inch in diameter. The hole, however, goes clear to the point.

That is designed to be put inside of an intact individual nerve cell and hooked through electrical amplifiers, in order to study electrical discharges and electrical phenomena in the individual nerve cell.

To give you some idea of the size of this, one of the larger nerve cells in what is known as the anterior horn in the spinal cord is about sixteen ten-thousandths of an inch in size. This can be inserted directly into the cell.

The little inside tube is filled with salt solution, to make contact with the wire up at the top.

You may wonder how that can be inserted in a cell which you can only see under a microscope. They have developed, along with this, what I call a gadget—they do not like that term—and what is known as a micromanipulator. By a very slight turn of this setscrew it moves this electrode an infinitesimal amount downward, and they watch the cathode-ray recording apparatus, and when it gives a certain kind of curve on the light that goes across it they know they are in the cell. This I am particularly proud of, because this was developed in our laboratory. The machine to do it was developed in our laboratory by a man trained on our program. Now we can get down to the basic element in the nervous system, the cell.

I will leave that here, in case anyone wishes to see it.

DRUG ADDICTION WORK

Because the care of drug addicts and the study of addiction long have been a concern of the Public Health Service, and one of the earliest in which the National Institute of Mental Health conducted studies, investigations in this field have been very productive. The Institute's Addiction Research Center at Lexington, Ky., has tested numerous drugs for their addictability, developed methods for simplifying and easing the withdrawal of patients from narcotics, explored the physiological bases of addiction, and made important findings regarding the personality characteristics and environmental background of addicted persons.

On the other hand, the gathering of statistical data to determine the extent of mental illness and define its types is a research activity in which the Institute has only recently been engaged. The Institute is working with State mental health authorities and representatives of State mental hospitals to develop standardized methods of gathering and reporting facts on the incidence of mental illness and the location of psychiatric facilities, so that a clearer picture can be obtained of the scope of the problem we face and how we can most efficiently direct our efforts.

Funds spent in mental research are indeed an investment, as they constitute the greatest opportunity for reducing the tremendous and rising cost of operating mental hospitals. There is great promise of

reducing not only these high expenses in the maintenance of mental institutions, but also of eliminating much of the suffering and anxiety which beset so many of our citizens. In this time of national stress, it is important that we enable each American to make the most of his abilities and to face the future with hope and courage. We believe that vigorous support of the training of mental health personnel, research in mental illness, and community preventive services will reap abundant dividends.

You might like to think a minute about what that $1 billion a year of mental health cost in tax dollars means in days and hours. It is $3 million a day, Mr. Chairman, and $2,000 a minute. Every minute every day of this year that much is involved, and it will be more next year.

Thank you, Mr. Chairman.

INCREASED PATIENT LOAD

Mr. BUSBEY. Thank you, Dr. Felix.

I noticed that on page 2 of your statement you referred to the increase in the percentage of persons in mental hospitals, and over on page 4 you mentioned the fact that odds for release back to the community are better than 50–50. I was under the impression that these new and improved methods of treating mental disorders would have a tendency to cut down the percentage of people in mental institutions.

Dr. FELIX. Well, there are 2 or 3 things that have happened, Mr. Chairman. The discharge rate has increased. But also the population has increased. That is one factor.

So if the admission rate per unit of population remained constant, you would have a larger number. Plus that there is the fact that there is an increasing number of people in the older age groups going in to mental hospitals. They stay in pretty well. There are methods we know which will permit a significant number of these to go out again, but they are not available in most hospitals because of lack of personnel.

Then, also, the treatment techniques that are being used are not available in all institutions, mental institutions, because of a variety of factors, so some of these patients stay in spite of the fact that if these facilities were used they would get out faster.

TRAINING GRANTS

Mr. BUSBEY. At the top of page 6, you mention the training grants which have been made available through the National Institute of Mental Health. How much has been spent by the Federal Government for these grants?

Dr. FELIX. I am not sure I understand. You mean how much we have spent total in this program, Mr. Chairman?

Mr. BUSBEY. Yes.

Dr. FELIX. Could I supply that for the record?

Mr. BUSBEY. Just approximately; or else supply it for the record.

Dr. FELIX. I would like to. I am afraid I will misstate it by a significant figure. I have it, but I just did not bring it with me.

(The information is as follows:)

The total sum of training grant obligations from fiscal years 1948 through 1952 and estimated obligations for fiscal year 1953 is $16,252,554, as follows: Graduate grants $14,178,447; undergraduate grants $1,805,136; training activities $268,971.

Mr. BUSBEY. What would happen if the Federal Government had not spent all this money?

Dr. FELIX. We would not be anywhere near where we are, Mr. Chairman. There are something like, I would say, three times as many people being trained today as there were when this program started.

In addition to that, where originally only a very small fraction of these people were going into public service or into research or into teaching, that number has about tripled, also.

For instance, not counting those in the armed services (which is a significant number among our psychiatrists alone), before we started this program, only about 15 percent of the psychiatrists trained went into public service, teaching, or research. Now it is nearly 50 percent In only 5 years we have increased the percentage that much, of those going into these institutions or State programs. That would not otherwise have been true, we know, because of the emphasis we have given in our program and the way we have publicly described these aspects of the program.

STATE MATCHING FUNDS

Mr. BUSBEY. In the next paragraph on page 6 you refer to the Federal grants-in-aid to the States. Are the States required to match these funds in any way?

Dr. FELIX. Yes, sir; they are. They are required to match 50 cents to the Federal dollar. As a matter of fact, they are now matching about $2.70 some to the Federal dollar. That has been an increase. It was about 50 cents of State money to $1 Federal money originally on the average over the United States.

Mr. BUSBEY. Is that a formula? Is it in the basic law that they have to match those funds?

Dr. FELIX. The law requires a formula be used. I believe the formula is developed by regulation. Am I correct in that? I think that is true. I think it is by regulation.

Mr. HARLOW. The matching requirement is by regulation.

Dr. FELIX. Yes.

BUDGET ESTIMATE

Mr. BUSBEY. Your request for fiscal year 1954 is $15.5 million, or an increase of $4,605,000. However, we have the proposition of comparative transfers, which we just discussed with regard to the Cancer Institute, which results in a transfer from other appropriations estimated to be about $76,000. Therefore, in reality the increase in this request is $4,681,000.

Dr. FELIX. Yes, sir; that is correct, Mr. Chairman.

COMPARATIVE TRANSFERS

Mr. BUSBEY. Would you briefly state for the benefit of the committee the reasons for these two comparative transfers?

Dr. FELIX. I would be glad to, Mr. Chairman. One comparative transfer is in the amount of $74,000. That represents training grants which the National Institute of Mental Health had been making to departments of neurology in several medical schools in order to improve this training. We started this before there was an Institute of Neurological Diseases and Blindness. When the Congress created the Institute of Neurological Diseases and Blindness and they got into operation, we transferred this function with the money to them because it is properly in their province.

The $2,000, Mr. Chairman, is a transfer to the appropriation known as "Salaries and expenses, Office of General Counsel, Office of the Administrator, Federal Security Agency."

Dr. SHANNON. May I amplify that point, Mr. Busbey? That $2,000, or a comparable figure, appears also in heart and in cancer. The total sum is $9,800 and is to pay the salary of a counsel who physically has taken up residence at NIH, to solve certain of our legal problems incidental to the opening of the clinical center, and other problems of that sort. From here on that will be carried in the agency budget. There is $2,000 from Mental, $2,000 from Heart, $3,000 from NIH, and $2,800 from Cancer.

REQUESTED FUNDS FOR CLINICAL CENTER

Mr. BUSBEY. How much of the request for 1954 is directly attributable to the opening of the new clinical center?

Mr. HARLOW. $641,900, Mr. Chairman.

(NOTE.—The figure shown is gross—the net increase in the appropriation needed for clinical-center operations is $592,700.)

Dr. SHANNON. Those are the costs attributable to the clinical center, but they do not represent the increases.

Mr. HARLOW. Yes, they do.

Dr. SHANNON. I am sorry. Yes, sir.

WORK ON DRUG-ADDICTION PROBLEM

Mr. BUSBEY. You discuss in the justifications on pages 129 and 130 the problem of drug addiction. Just what are you doing on this problem?

Dr. FELIX. We are doing several things, Mr. Chairman. We are continuing, and have continued for over 15 years, work on this problem.

The Institute of Mental Health and its predecessor, the Mental Hygiene Division, has conducted research at the laboratory at Lexington, Ky., where we study what drug addiction does to the body. There are various drugs which are synthesized which seem to be good substitutes for the habit forming narcotic drugs. And we also study methods of treatment, withdrawal of drugs, and other methods of treatment.

In addition to that we are conducting a study now in New York City designed to find out why it is that certain youngsters—by this I mean people under 21—in the same community and the same environment break down, if you wish to use that term, and become drug ad-

dicts, while their fellows across the street or in the next block do not. Why do certain people become drug addicts and others not?

The factors on the surface of it look as though they are fairly identical except that, of course, none of us are quite identical. We want to find out if we can, because if we can find this out we think we can begin really to strike at the heart of the drug-addiction problem by striking at the beginning of it, when the young people first become addicted.

Those are our principal activities, Mr. Chairman.

RELATIONSHIP OF DRUG ADDICTION WORK TO "HOSPITALS AND MEDICAL CARE"

Mr. BUSBEY. How is this related to the work being done under the appropriation "Hospitals and medical care"? For instance, on page 83 of the justifications for the latter appropriation request is an item of $48,500 for a followup system to obtain basic knowledge concerning the long-range effectiveness of the therapy being given to narcotic addicts.

Dr. FELIX. Yes, sir; I know about that, Mr. Chairman.

They are following up patients treated at Lexington and discharged from Lexington as cured, who are going back to a community where they can follow a number of them. They are following them up over a long period of time in order to find out if they relapse and if they do how early they relapse and how they can relate this to the kind of treatment that they are getting and the success or failure of the treatment.

We on the other hand are trying to go into this problem a little differently in our program, since we do not have any obligation as the Hospital Division does for the treatment of these individuals per se, and we are trying to find out what makes an addict in the first place.

Have I explained that adequately to you, Mr. Chairman?

TECHNICAL ASSISTANCE TO STATES

Mr. BUSBEY. Yes.

Why do you need $398,000 and 59 people to render technical assistance to States?

Dr. FELIX. Well, Mr. Chairman, there are several items in there which I think you would be interested in knowing about.

In the first place, because of the state of development of the mental-health program—remember, only 5 years ago there were only 22 States that had any program aside from the care of patients in mental hospitals. I am sure you know, also, that this was none too good in most of these. We have in the various regional offices consultants who work with the States at their request, bringing to them information about various mental-health activities going on in the States in their regions, and they come in for conference and pool their information with those men from other areas of the United States. Therefore, State A can know that State X is doing certain things quite successfully, and it can be brought directly to them.

In addition to that we have a group of experts in various aspects of mental-health problems in the headquarters office, who are available to any of the States. For instance, we have one man who is one of

the Nation's 3 or 4 leading authorities in mental deficiency, an area which has been sadly neglected up to the last 2 or 3 years.

We have another man who spends his time working with the State alcohol-control people. He does not have to do with the package stores, but rather with the program of treatment and control of alcoholism. There are about 30 States now that have programs of this kind. He is an expert in alcoholism.

We have a health educator who is particularly trained in the field of mental hygiene.

Then, in addition to that, in order to bring to bear on our program the thinking and the attitudes and the feelings of need of the various parts of the country we have a panel, which we call the Community Services Committee. This is made up of individuals who have no other connection with the Federal Government, who are State health officers or who are State mental-health authorities, superintendents of hospitals, educators, and so forth. They meet with us once or twice a year and present to us this other aspect of the program, which we tend to get a little blunt on if we do not keep in close contact with the communities.

Those are the principal activities. The chief of these activities, of course, is the regional-consultant program.

Mr. BUSBEY. Is not a great deal of that information and knowledge disseminated in the States and communities through medical journals and other publications?

Dr. FELIX. Well, Mr. Chairman, there are a host of medical journals. There are a tremendous number. I cannot keep up myself, for instance, adequately with the medical literature in the field of psychiatry.

I am also trained as a health officer. When I add the literature in the field of public-health and disease control I just cannot keep up with it. Neither can these people.

These people with whom we are dealing are administraors. They have jobs to do. They have to do as I am doing now, appear before legislatures. They have a host of responsibilities.

I know from my personal experience that it is much, much more effective in time and actually in what I absorb if a man with experience comes in and sits down with me and spends an hour and says: "This is what we have found in our area, and this is good."

DEMONSTRATION CLINIC IN PRINCE GEORGES COUNTY, MD.

I forgot one thing, Mr. Chairman. I should like to insert here one function which is very important in this technial assistance which you mentioned. That is our demonstration clinic in Prince Georges County, Md., which is a part of the Prince Georges Health Department. I think that is on the question of this very thing of which I am speaking. Our records show that each year official representatives from something on the average of 20 States come and see what we are doing there and carry this back. I have found the elements of this program in a number of States where I have visited.

In addition to this there are usually some 12 to 15 foreign countries represented each year in the people who come there to see what we are doing.

To go back to what I said before, I wanted to mention the person-to-person contact. I want to be sure I did not omit something.

For instance, you ask: "Yes, but I do not understand that now. How does that work?" And you are able to receive a ready answer which you cannot get from the printed page. That is much, much better.

I can sit down in my office, and so can these other officials, and make an appointment from 10 to 11 on Tuesday to see Dr. X, but I cannot sit down from 10 to 11 on Tuesday and read a stack of medical journals. It just has become a physical impossibility.

Have I made myself clear?

Technical Assistance Rendered to States by Public Health Service, 1952–54

Mr. Busbey. Yes, I think you have covered the subject well, Dr. Felix. But there are a great many people under different appropriations giving general or specific technical assistance, advice, and counsel to the States. Such activity comes in under "Assistance to States, general," "Control of venereal diseases," "Control of tuberculosis," "Control of communicable diseases," "Mental health activities," and so forth.

Dr. Scheele, would you have prepared a statement for the record showing the number of positions devoted to this type of service and the total cost for 1952, the total estimated cost for 1953, and the total estimated cost for 1954 for the Public Health Service, broken down by appropriations.

Dr. Scheele. Yes, sir, Mr. Chairman. That may not be easy to assemble in a hurry, but we will do our best to get it together.

Mr. Busbey. Without objection that will be inserted in the record at this point.

(The information is as follows:)

U. S. Public Health Service—Cost of technical assistance to States

Appropriation title	1952 actual		1953 estimate		1954 estimate	
	Position	Amount	Position	Amount	Position	Amount
Control of venereal diseases	228	$1,389,897	155	$1,043,000	150	$1,020,000
Control of tuberculosis	259	1,833,884	232	1,787,480	181	1,211,000
Assistance to States, general [1]	550	3,156,544	520	3,092,800	559	3,208,000
Control of communicable diseases [2]	1,211	5,616,759	1,118	5,407,750	1,084	5,240,000
Engineering, sanitation, and industrial hygiene [3]	458	2,820,046	438	2,781,000	455	2,889,000
Disease and sanitation investigations and control, Territory of Alaska	16	132,557	18	118,000	15	118,000
Salaries and expenses, hospital construction services [4]	162	1,115,273	162	1,090,440	162	1,090,440
Salaries, expenses, and grants, National Cancer Institute	79	397,074	79	400,000	79	400,000
Mental health activities	66	425,744	59	398,000	59	398,000
Salaries, expenses, and grants, National Heart Institute	60	308,416	57	345,000	57	345,000
Dental health activities	119	789,564	119	800,000	119	800,000
Total	3,208	17,985,758	2,957	17,263,470	2,920	16,719,440

[1] Includes vital statistics activity.
[2] Includes general disease-prevention and control activities, specific disease-prevention and control activities, and general epidemic and disaster aid.
[3] Includes industrial hygiene, water-supply and water-pollution control, and general sanitation activities.
[4] Includes operations and technical services activities.

Dr. SCHEELE. Mr. Chairman, one reason for the appearance of this in so many lines of our appropriation is the fact that these are specialists in different fields. Since there are many different individual lines the fact is that each is covering a range of specialties or a single specialty. The Mental Health people, for example, could not serve in the cancer field. We do try where we can to give general consultation through generalists, yet there are the special problems.

Mr. BUSBEY. I am not saying that it is not necessary and practical and that it should not be done; it just seems to me that we do have a lot of these people under several different appropriations furnishing information and giving technical assistance to the States. I wonder if there is not some other way that it might be handled more efficiently. Maybe there is not.

Dr. FELIX. I have an analogy, Mr. Chairman, which I find helps me to keep this clear.

Let me keep this in my own field. I was going to use law, but that is out of my field.

In a medical school we train the young men to be doctors; generalists to start with. But a surgeon teaches them surgery; an internist teaches them internal medicine; a pediatrician teaches them pediatrics; a psychiatrist teaches them psychiatry; because these people know the details of the various aspects of the program germane to their particular activities.

Now, this applies in these States. Remember that 5 or 6 years ago there were no programs like this, except in only a few States. The man says: "What do I do in a situation like this?" Only a person who is specialized in this area and who also specializes in public health, so that he can apply the psychiatric techniques to public health practice, can give this to the man or woman, the official, in a way that he can use it effectively.

We are trying, in other words, to weave into the general public health practice the mental health practice, but until that is woven in and until this becomes as much a part of the public health practice as some of the old, old programs, such as control of epidemic diseases, let us say, we are going to have to have a few people, at least—later on not as many as now—who can give this information to the people from their specialized point of view.

I suppose in a law school one would say that one person would teach corporation law and someone else would teach some other kind of law, because they are specialists. That is an analogy which helps me visualize this and express what I feel about it.

Mr. BUSBEY. I think we are all agreed that we have arrived at the point in our cultural development where there is a field of specialization for nearly every conceivable subject.

Dr. FELIX. I am afraid so.

Mr. BUSBEY. The old family doctor who took care of everything has almost passed out of the picture.

INCREASING PATIENT LOAD

Mr. FOGARTY. Doctor, in your opening statement you said there were 580,000 people in mental hospitals as of 1951; is that right?

Dr. FELIX. Yes.

Mr. FOGARTY. That is the 1951 calendar year?

Dr. FELIX. For the calendar year 1951, Mr. Fogarty, it was 580,000.

Mr. FOGARTY. That was an increase of 30,000 over the previous year?

Dr. FELIX. That is correct, sir.

Mr. FOGARTY. So this problem is increasing with the increase in population.

Another factor you mentioned in your report was that the people over 60 years of age have increased about 25 percent.

Dr. FELIX. That is correct; yes, sir.

Mr. FOGARTY. So the longer people live the more susceptible they are to some of these diseases?

Dr. FELIX. That is correct, Mr. Fogarty, plus one other thing. Our children growing up are growing up in a very stressful time. I mean the emotional stresses are on these children. As they go into adolescence and later adolescence we see a number of these who, because of a variety of factors, cannot handle the situation and break down mentally, also.

Mr. FOGARTY. Although you have made gains by the various techniques which have been developed for treating mental illness the population in hospitals is still on the increase.

Dr. FELIX. That is correct. Did we not have this program in operation you would have seen a significant increase by now over the figure that is quoted here.

SCHIZOPHRENIA

Mr. FOGARTY. I think one illness you talked about was schizophrenia.

Dr. FELIX. Yes, sir.

Mr. FOGARTY. It seems to me that a few years ago we did not know anything about it.

Dr. FELIX. That is correct.

Mr. FOGARTY. As I understand it, more than 50 percent of all the people in mental institutions have this particular disease.

Dr. FELIX. That is correct, sir.

Mr. FOGARTY. If you get it in time you can do something about it?

Dr. FELIX. If you get the cases early, within 18 months or 2 years as an outside figure, on some of them that break down, your chances are a little better than 50–50 that you can bring this person back to health and get him back out in the community.

Mr. FOGARTY. How do you know he is a schizophrenic?

Dr. FELIX. There are certain symptoms which, when taken together, give you the picture of what is known as schizophrenia. These consist of a very flat picture emotionally. By this I mean they do not become elated and they do not become depressed. They just do not fluctuate from a mean level of emotions.

Another interesting phenomenon which we see in these patients is what we call errors in association. In other words, I say something to you and this will normally make you think of certain things. With these patients it may not at all. They may think of something quite different, and are acting on this and their behavior becomes bizarre. I believe I quoted before this committee last year or the year before the classic case described in one of the textbooks, in which a schizophrenic patient was asked: "Who was Julius Caesar?" and the answer

was: "Julius Caesar was an Italian." This is a historical error. There was no Italy when Julius Caesar lived. There was Rome. But he brings this back into modern times, because Rome is now in Italy, and acts upon this.

I had a case one time in which I asked the patient a simple question. He had a peculiar depression in his breast bone, and I asked him if he had ever been a shoemaker. There is a condition known as "cobbler's breast" which comes from holding the shoe anvil up close, and the breast does bend in a little.

I asked him if he had been a shoemaker, and he violently jumped up and began to wring his hands and said: "I'm not going to die. You can't kill me. I'm not going to die." It took me several months to find out what this was all about. He had had a brother who had been a shoemaker, who died of a heart attack. I said: "Have you ever been a shoemaker?" and he thought he was going to die. This causes the difficulty.

Mr. FOGARTY. Is the average practitioner in a position to diagnose the schizophrenic patient?

Dr. FELIX. They are becoming more so, Mr. Fogarty. They were not a few years ago, as you know.

Under our program we have improved by a considerable degree the teaching of psychiatry at about 42 of the medical schools. These young men are in a much better position not only to diagnose but to be alert for the need of treatment of this kind of a patient. Still, this is only 13,000 who have come out so far, out of a total of I do not know how many thousand physicians in the country.

Mr. FOGARTY. A schizophrenic who has had that disease for 5 or 6 years will probably be a schizophrenic for life, and he will have a normal life span; is that not right?

Dr. FELIX. Physically.

Mr. FOGARTY. He will spend that time in an institution.

Dr. FELIX. That is correct. That is the tragedy. Not only does he live a normal life, but because of the remarkable developments of physical medicine with our miracle drugs to cure diseases which used to take these people off—pneumonia and infections—these things do not kill any more.

We know, Mr. Fogarty, that if a schizophrenic patient stays in the hospital for 5 years his chances of getting out alive are practically zero. It is not quite that. A few do, but it is almost zero.

Mr. FOGARTY. But he can still be expected to live a normal span of life?

Dr. FELIX. To live out a normal span of life.

Mr. FOGARTY. Maybe 30 or 40 years?

Dr. FELIX. That is correct. The average length of life of a schizophrenic in our public mental hospitals—remember, this is the average, and some live much longer and some come in later—is 28 and a fraction years in the hospital.

Mr. FOGARTY. Now, as a result of research if you get a schizophrenic in time you can do something about it. You say 50 percent of them can be successfully treated?

Dr. FELIX. Yes, sir. As a matter of fact, the figures are a little better than that, but I am always afraid that somebody will read the record and draw too sanguine conclusions. There are about

22,000 schizophrenics admitted for the first time to public mental hospitals each year. We have it down now to where 6,000 of these remain for life. The remainder get out.

That is better than 50–50, but there is a catch in this. Some of these come back after several years for a second time. So our figure of 50–50 I think is a much safer one to use. This is considerably better than it was 5 years ago.

COST OF MENTAL ILLNESS

Mr. FOGARTY. You assert in your statement that it is costing the public over $500 million to take care of these patients in mental institutions.

Dr. FELIX. That is correct, sir.

Mr. FOGARTY. The Veterans' Administration is paying $360 million a year to veterans suffering from neuropsychiatric disorders.

Dr. FELIX. Yes, sir. That is pensions, Mr. Fogarty.

Mr. FOGARTY. That is just in pensions?

Dr. FELIX. Yes, sir.

Mr. FOGARTY. That does not take into consideration the hospital care?

Dr. FELIX. No, sir.

CARE AND TREATMENT OF VETERANS

Mr. FOGARTY. Have you any idea what it costs the Veterans' Administration for hospital care for these veterans?

Dr. FELIX. If you wish it, I would like to supply it for the record, because that is from another department and I am not sure I would be stating it correctly.

(The information is as follows:)

The Veterans' Administration states that the cost for care of patients in its 34 neuropsychiatric hospitals was $152,439,747 in fiscal year 1952. There are, in addition, 8,000 neuropsychiatric beds scattered throughout the Veterans' Administration, general, medical, and surgical hospitals, the cost of which is not readily available. In addition to the cost of hospitalized patients, the Veterans' Administration in fiscal year 1952 calculated that $7 million was expended for 722,077 out-patient treatments to 177,747 veterans.

Mr. FOGARTY. So all in all it is costing the taxpayers about $1 billion a year?

Dr. FELIX. Yes, sir; and it is increasing at the rate of about $100 million a year. It has for the last several years.

Mr. FOGARTY. The Veterans' Administration thinks that by 1960 100,000 veterans will be eligible for hospital care?

Dr. FELIX. Yes, sir. That is the psychotics. That does not count the neurotics and so forth. These are, to use the common word, the actually insane.

Mr. FOGARTY. What will be done if we do not have the psychiatrists to man these hospitals?

Dr. FELIX. I do not know. I do not know what we can do. The States will have to take this over. They do not have the facilities nor the staff at this time. I do not know how they will have them by 1960, unless a lot of people come off the production line who are not in training at all yet.

Mr. FOGARTY. It looks to me as though this is one of the most serious problems we are facing in the health field today. It is also one of the most costly.

Dr. FELIX. It is my opinion that you are correct in both statements. I am certain you are correct in the latter, and I feel certain you are correct in the first statement; although I may be biased, because this is my field. But I think the dollars speak pretty well for themselves.

Mr. FOGARTY. If we can find ways of preventing some of these diseases that would help bring down the cost, would it not?

Dr. FELIX. Yes, sir; that is true.

PROPORTION OF RESEARCH FELLOWS AND TRAINING GRANT RECIPIENTS WHO SUBSEQUENTLY ENTER PRIVATE PRACTICE

Mr. FOGARTY. There was some concern expressed here yesterday, Doctor, about the possibility that some of the physicians who have taken advantage of your postdoctoral training courses might have done so to help their own practices. What is the situation so far as your particular program is concerned. What has been the subsequent history of the doctors who have taken these postgraduate courses with the help of the Federal Government?

Dr. FELIX. A certain percentage of them are in the military. Whether they will stay or not I do not know.

Laying that group aside, of the remainder practically 50 percent—forty-odd percent—are devoting full or a significant part of their time, and by that I mean up to 50 percent, in public service. I include in public service the teaching and research, since this is not private practice. Five years ago our best figures showed that only 15 percent of the psychiatrists who were trained went into other kinds of work than private practice. So, we have an increase of about threefold in 5 years. I think this will increase even more than that.

Mr. FOGARTY. What is the average of those who take advantage of this program just for their own benefit?

Dr. FELIX. Well, it is considerably less than 50 percent. The reason I have to put it that way is this: A number of these men who are in private practice will be teaching in a university 2 or 3 hours a week, or they will be giving of their time a half day a week or a day a week in a clinic or something of that nature, and we do not have records of that. This is a public service which any professional person would give. So, it is under 50 percent after 5 years.

BENEFITS OF PROGRAM

Mr. FOGARTY. What is the advantage to the taxpayer of training these doctors with the help of Federal funds?

Dr. FELIX. The advantage is this, Mr. Fogarty: In addition to the advantage for our public programs, there is such a terrible shortage of psychiatrists in the United States that if you can pay any amount of money, almost, you cannot in many areas—and Washington is one—get a psychiatrist right now. If one of you needed psychiatric help, you would very probably find that you would be put on a waiting list and would be gotten to somewhere between 3 weeks to 6 months from now. There just are not enough.

Now, I come from an old Kansas family, which believed that the Lord helps those who help themselves, and I cannot get away from that point of view. I think it is just as important that if I can pay something for my care that I should be able to find someone who can give me this care. That is basic.

Another thing is this: If these people are not gotten hold of early and brought back to health, the family eventually exhausts all of its resources, which it possibly can put into it. We all know of many cases like this. Then they wind up in the State hospital anyway.

Just to give us an idea of what this is in dollars, as of 1949—we have not calculated it since, and it is more than that—the average cost of hospitalization of a person in a public tax-supported institution during the entire period of hospitalization is $7,000. It is more than that now. If a psychiatrist could prevent only 10 patients a year, less than 1 a month—I use the figure 10 deliberately, because I can calculate in 10's easier than in 12's—by stopping 10 patients a year from entering a mental institution that would be a saving of $70,000 a year. If the man only had 20 years of active professional life, that would be $1.4 million of saving in tax money so far as people who were kept out of the hospital is concerned.

Now, if the persons saved were people who paid something for their care, or if they were taken care of in public tax-supported clinics, really, so far as my pocketbook is concerned, this in the final analysis does not matter too much. I am saved the hospitalization kind of money, or my share of it.

DIFFICULTIES OF ATTRACTING YOUNG MEN TO PSYCHIATRIC FIELD

Mr. FOGARTY. It has been difficult in the past to get young men to specialize in psychiatry, has it not?

Mr. FELIX. That is correct, sir.

Mr. FOGARTY. They seem to go into other fields. Why are the other fields more attractive?

Dr. FELIX. It takes at least 4 years after your internship, and usually 5 years after internship, before you are completely prepared.

Suppose that a young man graduates from medical school at 26 or 27. I think that is about the average age, or something like that. He spends 1 year in an internship. Let us put this at 26, and then he is 27. He would have to put in 5 years after that, and then he is 32. If he is going to do that, he has not been able to have a family. Maybe he has one child, or maybe he has not even thought he could get married.

In my own case I did not marry until I had finished psychiatric training, because I did not feel I could support a wife. I graduated from medical school a little younger, and I did not take all 5 years. Twenty-five years ago they did not get that much. However, I was 29, or nearly 30, myself when I married.

My colleagues in other specialties, my classmates, who went out into general practice, had been in practice for 4 or 5 years before I got out. This cuts down the number of years of active life which a man has of productive life with income. This is important.

If a person, let us say, likes surgery and psychiatry, one the same as another, and he can get into practice a little earlier in one than

in the other, he is going to take the one where he can get out into it earlier.

Besides all this, psychiatric training is an extremely grueling experience. Before you can treat other people you have to understand yourself perfectly. You have to know what makes you mad, and why. If I see—I am pointing to a vacant chair deliberately—this person over here, who irritates me for some reason, and if I just constitutionally do not like that person and I do not know any reason for it, there are always reasons for these things. I have to understand what these reasons are before I can take that gentleman who needs help and give him treatment. Now, this gets into some pretty painful areas in one's own personality, when you begin to understand why you do like certain things or do not like other things. The actual unpleasantness of going through psychiatric training deters many people from going into it.

Mr. FOGARTY. This is still a pretty big problem, then, of getting the necessary personnel to deal with these problems?

Dr. FELIX. That is correct.

Mr. FOGARTY. There is still quite a shortage of trained psychiatrists?

Dr. FELIX. That is correct. Today we could use or we could absorb in no time 15,000 more psychiatrists, if we had them.

QUACKS AND PSEUDO-PSYCHIATRISTS

Mr. FOGARTY. What, if anything, is done to expose these so-called quacks in psychiatry who are running ads in newspapers and otherwise advertising for patients?

Dr. FELIX. If a man is actually a psychiatrist, that means he is an M. D., a doctor of medicine. A person is not a psychiatrist unless he is first a physician. Anyone else who says he is a psychiatrist is misrepresenting himself. They may be something else, but they are not psychiatrists. You have to be a physician first. He then comes under all of the ethical provisions or regulations of our profession, among which is an interdiction against advertising.

We cannot prevent other people from advertising, provided they do not misrepresent themselves and call themselves psychiatrists or something of that nature.

Mr. FOGARTY. What do they call themselves?

Dr. FELIX. They call themselves character analysts.

Mr. FOGARTY. Psychoanalysts?

Dr. FELIX. Psychoanalysts. That is not true, either, because a psychoanalyst is also a physician. But there is no law which says a person cannot call himself that. They call themselves personality counselors, and all kinds of things of that nature.

Am I correct in saying that these people are comparable to what we used to call sea lawyers, who were ready with advice but did not have the skill and background to support it?

Now, in some States there is being pushed legislation to bring all kinds of psychotherapy under the medical practices acts of these States. I sincerely hope this goes through. This will fix it.

Mr. FOGARTY. It is a pretty thriving business as of today; is it not?

Dr. FELIX. Yes, it is.

Mr. FOGARTY. Especially in a city like Washington, I would presume.

Dr. FELIX. Yes, sir. If I were not on the record I could get a little vehement about that.

We have a number of people involved. You see them down on the street with a sign out with a palm on it, or something of that nature.

Now, do not misunderstand me, Mr. Fogarty. I am afraid I will be misunderstood here. There are certain kinds of people who are quite qualified to do certain kinds of counseling. You have heard me before mention the great importance of adequate orientation of the ministers, the priests, the rabbis, the pastoral counselors. But the seminaries give courses in this, so the clergymen know what they are doing.

About 40 percent of the people with problems go to their clergymen, and these people must be trained in that. The same is true of the psychologists whom you find in the school programs, counseling students, and so forth. But these are not psychiatrists.

Mr. FOGARTY. That is all, Mr. Chairman.

Mr. BUSBEY. Mr. Fernandez?

Mr. FERNANDEZ. No questions.

Mr. BUSBEY. If there are no further questions the committee will stand adjourned.

TUESDAY, MARCH 31, 1953.

NATIONAL HEART INSTITUTE

WITNESS

DR. C. J. VAN SLYKE, ASSOCIATE DIRECTOR, NATIONAL INSTITUTES OF HEALTH

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$10,082,650	$12,000,000	$16,500,000
Transferred to "Hospitals and medical care, Public Health Service," pursuant to Public Law 375	−100,000		
Adjusted appropriation or estimate	9,982,650	12,000,000	16,500,000
Prior year balance available (contract authorization)	3,124	3,124	3,124
Reimbursements from non-Federal sources	35		
Total available for obligation	9,985,809	12,003,124	16,503,124
Balance available in subsequent year	−3,124	−3,124	
Unobligated balance, estimated savings	−132,861		
Rescission of contract authorization			−3,124
Obligations incurred	9,849,824	12,000,000	16,500,000
Comparative transfer to—			
"Assistance to States, general, Public Health Service"	−34,415		
"Neurology and blindness activities, Public Health Service"	−142,259	−191,000	
"Salaries and expenses, Office of the Administrator, Federal Security Agency"	−20,032	−32,000	
"Salaries and expenses, Office of the General Counsel, Office of the Administrator, Federal Security Agency"		−2,000	
Total obligations	9,653,118	11,775,000	16,500,000

NOTE.—Reimbursements from non-Federal sources above are from the proceeds of sale of personal property (40 U. S. C. 481 (c)).

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
1. Grants:			
(a) Grants for research and training:			
(1) Research projects	$4,679,602	$4,927,000	$5,070,000
(2) Research fellowships	300,000	450,000	357,000
(3) Teaching of medical subjects	740,961	1,373,000	1,373,000
(4) Training stipends	147,733	250,000	250,000
(5) Construction of research facilities			4,000,000
(b) Grants for detection, diagnosis, and other control activities	1,286,367	1,500,000	1,500,000
2. Direct operations:			
(a) Research	1,915,438	2,615,400	3,322,000
(b) Other direct operations:			
(1) Review and approval of research and training grants	83,262	90,100	90,000
(2) Technical assistance to States	308,416	345,000	345,000
(3) Administration	191,339	224,500	193,000
Total obligations	9,653,118	11,775,000	16,500,000

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Total number of permanent positions	356	416	416
Full-time equivalent of all other positions	12	12	12
Average number of all employees	311	379	400
Average salaries and grades:			
General schedule grades:			
Average salary	$4,191	$4,166	$4,166
Average grade	GS–5.8	GS–5.8	GS–5.8
01 Personal services:			
Permanent positions	$1,418,793	$1,811,363	$1,904,063
Part-time and temporary positions	50,949	54,540	54,540
Regular pay in excess of 52-week base	3,384	5,091	5,091
Payment above basic rates	3,592	3,610	3,610
Total personal services	1,476,718	1,874,604	1,967,304
02 Travel	68,816	78,950	78,450
03 Transportation of things	5,470	13,900	10,300
04 Communication services	11,058	10,000	10,000
05 Rents and utility services	4,000	4,000	4,000
06 Printing and reproduction	10,649	12,500	12,500
07 Other contractual services	52,824	96,550	52,550
Reimbursements to "Operating expenses, National Institutes of Health, Public Health Service"	452,320	801,500	1,410,400
08 Supplies and materials	194,029	214,900	235,900
09 Equipment	224,464	168,800	168,800
11 Grants, subsidies, and contributions	7,155,073	8,500,000	12,550,000
15 Taxes and assessments	4,067	4,230	4,730
Subtotal	9,659,488	11,779,934	16,504,934
Deduct charges for quarters and subsistence	6,370	4,934	4,934
Total obligations	9,653,118	11,775,000	16,500,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$1,033,377	$1,525,080	$2,029,647
Obligations incurred during the year	9,849,824	12,000,000	16,500,000
	10,883,201	13,525,080	18,529,647
Deduct:			
Reimbursable obligations	35		
Adjustment in obligations of prior years	10,888		
Unliquidated obligations, end of year	1,525,080	2,029,647	6,029,647
Obligated balance carried to certified claims account	37,621		
Total expenditures	9,309,577	11,495,433	12,500,000
Expenditures are distributed as follows:			
Out of current authorizations	8,461,774	10,600,000	10,875,000
Out of prior authorizations	847,803	895,433	1,625,000

Amounts available for liquidation of contract authorization

	1952 actual	1953 estimate	1954 estimate
Prior year balance available	$3,124	$3,124	
Balance available in subsequent year	−3,134		
Carried to surplus		−3,124	
Obligations incurred			

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$3,183,747	$1,704,567	
Deduct unliquidated obligations, end of year	1,704,567		
Total expenditures (out of prior authorizations)	1,479,180	1,704,567	

Mr. BUSBEY. The committee has before it the appropriation request for fiscal year 1954 for the National Heart Institute. Dr. Van Slyke, who was the Director of the National Heart Institute and is now the Associate Director of the National Institutes of Health, will testify in regard to this request.

GENERAL STATEMENT

Dr. VAN SLYKE. Mr. Chairman and members of the committee, heart disease is a health problem of grave national concern for many reasons. It is our leading cause of death, accounting for 1 out of every 2 deaths in the United States. Last year diseases of the heart and blood vessels took more than three-quarters of a million lives. Contrary to the common impression, heart disease is not limited mainly to the older age groups. More than one-third of the deaths it causes are at ages under 65. It takes a great toll among those in the prime of life. In the productive years, heart disease is the chief killer. Even in children of 5 to 14 years of age, it ranks very high as a cause of death.

Between 9 and 10 million Americans suffer from heart and blood vessel diseases today—this is about 1 in every 15 or 16 of our citizens. Each of them is prevented to some degree from living a full, normal, active life. Uncounted thousands of them are seriously handicapped and many are totally incapacitated. It is obvious that the price paid for heart disease is great in terms of suffering, disability, and death.

Its price is equally staggering in social and economic terms. Most of us know of the tragedy that often results when heart disease strikes—children whose promising futures are blighted, men and women cut down when their contributions to society are richest, families whose security vanishes under the burden of invalidism or loss of the breadwinner. Heart disease exacts an enormous economic cost in medical and institutional care, in military manpower, and in industrial production. It is estimated that a minimum of 150 million work days are lost each year because of it. An indication of the tremendous dollar cost of heart disease is suggested by considering only one item in its total: Compensation and pension payments to veterans for disability from heart and blood vessel disease in the year 1950 alone was $168,250,000.

The problem is growing. Mortality from heart and blood-vessel diseases in 1935 was 450,000. Ten years later, in 1945, deaths from this cause were 592,000. In 1950, the figure reached 745,000, and preliminary estimates indicate that in 1952 heart deaths increased to 774,000. The problem is serious and becoming more so. It is urgent that every possible resource be exploited in the attempt to bring heart disease under control. The accomplishments which have been achieved in the 4½ years since the National Heart Institute was established bear witness that step-by-step progress can be made against this chief threat to our national health.

THE NATIONAL HEART INSTITUTE'S PROGRAM

The program of the National Heart Institute is planned and designed to meet the challenge of heart disease under the provisions of the National Heart Act. Through research grants, heart-research projects are being fostered throughout the Nation, and the Institute is carrying on laboratory and clinical studies itself. Construction of new research facilities has been made possible by grants; the training of much-needed research personnel is progressing through awards for this purpose; and epidemiological studies which bear an important relationship to future heart-program development are well under way.

The Institute's appropriation has also provided vital support for the development of organized public-health activities and training concerned specifically with heart disease. The programs of information and education, cardiovascular teaching, and traineeships are assisting in bringing to general application those preventive, diagnostic and treatment methods which are now accepted, as well as the new fruits of research which are being and will be garnered. The program of assistance to the States is promoting control measures, services, and facilities throughout the Nation.

NEW NATIONWIDE DRIVE FOR PREVENTION OF RHEUMATIC FEVER

Rheumatic fever is responsible for 90 percent of all heart disease in children and is a major cause of heart disease in adults. Among school children between the ages of 5 and 15, it is a chief threat to health. During World War II, more than 210,000 men were rejected by Selective Service because of rheumatic-valvular heart disease. Between 750,000 and 1,000,000 persons in the United States today are estimated to have rheumatic heart disease as a result of recurrent attacks of rheumatic fever.

With the national voluntary organization, the American Heart Association, and the Public Health Service working in close cooperation, in the past few months a new nationwide drive for the prevention of rheumatic fever has been launched and is progressing. Initiating this cooperative work, the Council on Rheumatic Fever and Congenital Heart Disease of the heart association issued recommendations for the prevention of rheumatic fever and rheumatic heart disease. These are being given the widest possible circulation among the medical profession and related groups and will be carried through to the general public. Within the past 2 months, they have

been published in the Journal of the American Medical Association, Circulation and Modern Concepts (official heart-association publications), Public Health Reports, and a number of other leading journals. These recommendations are a landmark in the march of progress against the disease.

Although we do not know fully the cause of rheumatic fever, there is an accumulated set of facts which are sufficient for saving lives and preventing much disability. The recommendations mentioned above are based on these facts and provide for the first time a sound platform for action.

With family physicians taking the lead, communities now can organize to combat rheumatic fever and its crippling companion, rheumatic heart disease. The immediate years will bring great gains, and we may see in our lifetime—through this and the new knowledges that research will also bring—the reduction of rheumatic heart disease from a major to a minor health problem.

GRANTS-IN-AID AND TECHNICAL ASSISTANCE TO THE STATES

While it is fully recognized that heart disease per se cannot today be wholly prevented or controlled, much can be done in several areas of cardiovascular disease to alleviate, delay, and, in certain instances, prevent total or serious cardiac disability. Early recognition, together with prompt and continuous medical care, including such auxiliary medical care as nutrition and rehabilitation, can mean maintenance of useful living in many individuals stricken by heart disease. The public health approach follows the pattern of professional and lay education; early recognition of the disease, together with prompt and continuous medical care, and cooperation among community facilities to provide the various types of necessary services.

The interest in this has grown strongly since the inception of support, through the National Heart Institute appropriation, for grants-in-aid and technical assistance to the States.

These funds and activities result in an expanding public health application of newer knowledges and techniques. Closer relationships are growing between more health departments, heart associations, medical societies, and other health and welfare agencies; a great deal of professional education and training are ensuing, and organization structures and practical ways to implement the heart disease aspects of community health programs are increasingly developing.

Professional education, including refresher courses for physicians and for nurses and other public health personnel, receives major emphasis. Many States provide seminars, courses, and consultation clinics for physicians. Important in professional education is the new bimonthly professional publication, the Heart Bulletin, designed solely to bring useful, up-to-date cardiovascular information to the physician in general practice.

With the States, the National Heart Institute and the American Heart Association and its affiliates cooperated in the planning, establishment, and dissemination of the publication, which began in March 1952. Over 70,000 copies per issue are distributed to physicians by health departments, heart associations, and medical societies in some 40 States, Territories, and local areas.

Through technical assistance to States, a series of demonstration activities dealing with the control of heart disease is conducted. One of the activities in this connection is cooperation with tuberculosis surveys so that chest plates which are taken to discover tuberculosis are also examined for possible indications of heart disease and for early referral to physicians of people with heart disease who did not previously know of the condition.

In another activity of this nature, a continuing program deals with the use of drugs which have to do with the clotting of blood—the type of treatment which saves the lives of many people afflicted with heart attacks. Those drugs cannot be used safely unless the patient is under close observation; otherwise, the blood becomes too thin and it is dangerous for the patient to be given the drugs. When accurate laboratory control is provided for the physician, these drugs are safe and lifesaving. However, in order to use them, laboratory people trained in the technique of determining quickly the blood-clotting time are vitally necessary. The demonstration activity and technical assistance by the Public Health Service in this field is to train or aid in the training of technicians and technician-teachers around the country through teams, which move from State to State, and thus setting up, in cooperation with medical groups and health departments within the States, teachers competent to instruct in the procedures.

This work carried out in conjunction with State and local medical societies and heart associations has progressed to the present point because of the help provided through the grant-in-aid and technical assistance funds of the National Heart Institute appropriation. The need for the programs which these funds make possible does not require emphasis. The cooperative activities they support are effective methods of getting at the vast problem of doing the many things that can be done with current and advancing knowledge to control heart disease.

HEART TEACHING GRANTS AND TRAINEESHIP AWARDS

The vast majority of heart patients are now, and will continue to be, treated by the physician in general practice. It is therefore important that medical schools have strong and up-to-date courses of instruction in heart disease so that medical students, from whom come the physicians of the future, may be well equipped with the most recent knowledge in this field. This is particularly essential because of the rapid and marked advances that are being made in research.

The particular direction the effort to strengthen and improve heart teaching must take varies from school to school and is determined by the medical school itself. In some places the major need is for differently trained personnel, in others for improved teaching equipment, and in still others for an expanded curriculum or greater coordination.

The National Heart Institute's program of teaching grants is enabling medical schools to expand and improve their teaching of diseases of the heart and blood vessels. This financial assistance has made it possible for the schools to undertake the planning, integration, revision, and expansion and heart disease instruction.

The number of cardiologists and physicians with specialized training in heart disease in active practice today is far too low compared with the amount of heart disease in the Nation. The Institute's

clinical traineeships program is providing a means of partly meeting this need for more clinical personnel specializing in heart and blood vessel diseases. This program is of marked benefit to the community because many of the young physicians thus trained go out to assist in teaching capacities in hospitals and medical schools as well as to general or specialized medical practice. The Heart traineeships are designed to improve the general level of practice with regard to heart disease by providing general practitioners and young internists with a sustained, intensified period of up-to-date instruction in an institution where well rounded cardiovascular instruction is given and where the individual may wish to study.

HEART RESEARCH FELLOWSHIPS

The basic objective of the Institute's heart research fellowships program is to provide more effective research workers through increasing their skills. This is necessary because of rapid advances in research techniques, many of which are complicated. One real advantage of the fellowships program is that training is received by active, day-to-day participation in scientific investigations and research projects. Thus the individuals add to the fund of scientific knowledge while at the same time they are acquiring skills. The program is increasing the caliber of research workers in medical and allied fields and contributing definitely to the research potential of the Nation.

RESEARCH PROJECT GRANTS

New advances are being made by heart research project grants, on a wide basic and clinical front, that would not have been possible without the support provided through this program. By way of example, recent progress by recipients of these grants includes—

(1) The successful use of an artificial heart on a human patient, carrying the patient's circulation while his own heart was being operated on;

(2) The development of new surgical operations which will remedy additional types of heart damage due to rheumatic and congenital heart disease;

(3) Advances in the techniques of preserving blood vessel grafts and their dramatic use to save and prolong lives;

(4) The improvement and successful use in patients, of plastic artificial heart valves including one for stopping backflow of blood into the heart due to an impaired valve leading into the great trunk (aortic) artery;

(5) The intensive study of lipo-proteins in relation to the development of the serious form of hardening of the arteries that leads to heart attacks, resulting in new basic knowledge which bring nearer the possibility of tests for the early discovery of the condition and measures to prevent or ameliorate it;

(6) Better understanding of the role of drugs such as ACTH and cortisone, and the knowledge that they do not as yet provide the complete answer to rheumatic fever and that the salicylates, such as aspirin, appear to be equally effective in treating the acute stage of the disease;

(7) The development of new drugs and the improvement of others as, for example, drugs such as hexamethonium and 1-hydrathalazine to reduce critical high-blood pressure;

(8) The improvement of anticlotting drugs and of methods of administering them so that they will better and more safely prevent blood clotting not only in patients suffering coronary attacks but also in those with other heart and blood vessel conditions;

(9) The further development of low sodium diets and their effectiveness in the treatment and management of high blood pressure.

The heart research work provided by National Heart Institute research grants has resulted in a widening and deepening of the total scientific effort devoted to the problem of heart disease. Speaking of the general effect of these and other Public Health Service research grants, an eminent non-Federal scientist recently said:

> The impetus which the United States Public Health Service is lending medical progress in this country in the support of biologic research is making an important impress on the whole range of medicine.

The need for continuing this program is indicated by the scientists and the institutions, hospitals, and universities where the work is being done. Effectiveness and accomplishments in this most important field are dependent upon strong, continued support.

HEART INSTITUTE RESEARCH

Much knowledge of heart disease can be gained by studying a community over a period of time to find out how many people have it, what types they have, at what ages it develops, and what factors seem to be associated with it. At Framingham, Mass., with the wholehearted cooperation of the town and by the active and continuing participation and cooperation of the town's physicians and health department and the State medical society and health department, such an epidemiological study is being conducted by the Institute. About two-thirds of Framingham's adult population, selected through a random sampling method from the town's people between the ages of 30 to 60, is being given a thorough examination to determine whether or not they have arteriosclerotic or hyptertensive heart disease.

Treatment is not given in the study, but for those individuals found to have heart disease or indications of it, the diagnostic information is given to the person's own physician. Persons found to have heart disease at the time of the first examination in the study are not included in the long-term follow up of the study, because its purpose is to learn how heart disease develops. Therefore, those who do not have heart disease at the time of the first examination will be given repeat examinations every 2 years.

This epidemiological approach, the only one of its kind under way anywhere, is expected to produce a number of significant results. It may provide definite information as to which factors or characteristics are present in people who develop heart disease. Findings of this kind may be of great importance in the prevention and treatment of heart disease in the future. Another useful result will be data on incidence and prevalence; that is, how many cases of heart disease there are and how many new cases arise each year. A further result of the study will be appraisals of the value and efficiency of various

methods and procedures for diagnosing heart disease. This may help lead to a simple way of quickly screening people to detect those who have heart disease.

The direct medical research conducted by the Institute encompasses investigations of a basic nature as well as the developmental and applied. These are an essential complement to the investigative studies provided through research grants projects. Since the research program is flexible and organized on three integrated levels (laboratory, combined laboratory-clinical, and clinical) it is able to cover gaps in the overall attack on heart disease which otherwise would not receive adequate attention. Although the current fiscal year is only the fourth year since the Institute began the full development of its research, work of brilliant promise has been done and outstanding achievements made.

Significant contributions have resulted from fundamental studies. It has been discovered that the liver plays a role in controlling the partial contraction of small blood vessels which is essential for maintaining normal blood pressure. It has been confirmed through experimental animal preparations that the kidney and the endocrine glands controlling it are of great importance in the development of heart failure. It has been learned that deterioration of organs due to growing older is not because of the aging of the organ cells themselves but rather due to there being fewer cells per organ available to achieve a given living requirement. It has also been discovered that there exists in the body a system of at least four chemical parts, a deficiency of any part of which may adversely affect fat metabolism and thereby foster hardening of the arteries—particularly that type which leads to "heart attacks" or "heart strokes." Those are all additions to the storehouse of basic data from which clinical applications in time develop.

The latter discovery is a major forward step in developments of our knowledge of hardening of the arteries (arteriosclerosis) and its most seriously damaging form (atherosclerosis). These studies may eventually lead to a method of treatment and perhaps of prevention. When anyone eats a fatty meal, fat is absorbed in the blood and gives it a milky or cloudy appearance. In normal persons the blood clears in a short time. In those with atherosclerosis the milkiness does not appear to clear as rapidly and completely. The fatty substances are not handled normally and the blood of such persons contains an excess of large abnormal fat-bearing molecules. Heart Institute scientists have found that a blood protein, a stomach or lung protein, and heparin, in the presence of a plasma coprotein, will combine to form a "clearing factor" that clears the milkiness of the blood. When "clearing factor" is added to the blood of persons with arteriosclerosis, the number of abnormal molecules is reduced and the number of normal molecules increased. Research is now under way on the next step—that of obtaining the components in pure form. When this is done, it may lead to a blood test to detect early hardening of the arteries, since it will then be possible to check a person's blood to find out whether or not one of the substances may be lacking. The possibility of prevention is also held out, since it may be that by administering the missing substance the further development of the disease may be arrested.

Among accomplishments of Heart Institute research resulting in improved medical treatment has been the development of a truly short-acting anesthetic which wide-scale clinical investigation indicates may be effective in reducing the hazards of surgery now experienced by elderly patients. This new anesthetic is safe, easily and quickly destroyed by the body, and administered intravenously. Another advance has been the development of a drug, procaine amide, for treatment of irregular heart rhythms which frequently occur, and may cause death, in patients recovering from coronary attacks and in persons under anesthesia during operations. Moreover, the drug appears to be effective in preventing the development of abnormal rhythms if given beforehand in situations where they might be expected to occur. The past year has seen a great increase in its use in medical practice and it is now being manufactured by at least three of the large pharmaceutical houses.

These achievements indicate some of the progress being made through research. Many compounds are being studied for their therapeutic value; many avenues and approaches seeking the causes and underlying cardiovascular-disease processes are being explored. Adequate funds for the Institute's research, especially for intensifying and broadening its coverage of the important problems it seeks to solve, is a strong need. Such fiscal support will supply high-caliber work and step up progress in the national heart-research effort throughout the Nation.

RESEARCH SUPPORT BY AMERICAN HEART ASSOCIATION

Mr. BUSBEY. Thank you, Dr. Van Slyke. How much is the American Heart Association spending per year on its work?

Dr. VAN SLYKE. Approximately $10 million.

Mr. BUSBEY. Do you have some idea as to how that $10 million is spent by the association?

Dr. VAN SLYKE. Roughly in the proportion and way that the American Cancer Society allots its funds to the support of research and back to the communities to carry out their control programs, clinical instrumentation and that sort of thing.

Mr. BUSBEY. What percentage of that would be for grants to medical schools and research specialists?

Dr. VAN SLYKE. In actual practice, although the formula may vary, about 50 percent of funds both at the national level and local level go to the support of research projects at research institutions, including medical schools.

COOPERATION BETWEEN INSTITUTE AND AMERICAN HEART ASSOCIATION

Mr. BUSBEY. Do you sit on the board of the American Heart Association?

Dr. VAN SLYKE. Yes; I do. I am a member of the board of directors, and I think the chairman of the committee will be pleased to learn that we have an interchange of staff meetings annually with the American Heart Association; so, we go completely into the conduct of their business and we provide knowledge to them of the conduct of our Heart Institute activities.

Mr. BUSBEY. Are the same procedures to avoid duplication applied as between the National Heart Institute and the American Heart Association that are applied as between the National Cancer Institute and the American Cancer Society?

Dr. VAN SLYKE. Yes, sir. I would say it is absolutely identical. Not only do we have the members of the American Heart Association attend our national advisory-council meetings, not only do we have this joint staff meeting each year, not only do we by personal contacts keep in very close touch with one another, but we have set up a scheme of routine interchange of research-grant information so that they know exactly what we are supporting and we know exactly what they are supporting. Further than that, we know the major things which are proposed in those budgets.

PUBLICATION OF THE HEART BULLETIN

Mr. BUSBEY. On page 5 you mention the new bimonthly professional publication entitled "The Heart Bulletin."

Dr. VAN SLYKE. Yes, sir.

Mr. BUSBEY. How much does it cost to publish that bulletin?

Dr. VAN SLYKE. That is published by a nonprofit organization, and I think—I would like to correct this figure in the record if I find it is wrong—I think it is $1.65 a year—$1.55 or $1.65 a year.

Mr. BUSBEY. The National Heart Institute has nothing to do with the publishing of the bulletin?

Dr. VAN SLYKE. No, sir; we do not, and we do not subscribe to it. Subscriptions to this are done by the State and local medical societies, by the public health departments, and by the local heart associations. This is the type of periodical publication which is aimed at getting the very latest information to the general practitioner. It is not aimed at helping out the specialist; it is not set at his level.

We have had a lot of very complimentary letters concerning it, because it seems to be effectively doing the job we set out for it, and I think the fact that in just about a year it has gone from a zero circulation to 70,000 indicates it must be of value.

Mr. BUSBEY. Who publishes it?

Dr. VAN SLYKE. It is published by the Sterine Medical Foundation of Texas. It is a nonprofit organization incorporated under the laws of Texas.

1954 BUDGET ESTIMATE

Mr. BUSBEY. The request for 1954 is $16,500,000, an increase of $4,500,000, and there are 3 comparative transfers related to work transferred to other appropriations that total $225,000, which would make a total actual increase of $4,725,000.

FUNDS REQUESTED OF BUDGET BUREAU

What was the original request of the Bureau of the Budget from the Institute?

Dr. VAN SLYKE. $17,998,000.

Mr. HARLOW. Which did not include the $4 million for construction.

Dr. VAN SLYKE. That did not include the $4 million item for construction, which our instructions precluded us from including in our budget.

Mr. BUSBEY. But $4 million was added by the Bureau of the Budget?
Dr. VAN SLYKE. Yes, sir.

COMPARATIVE TRANSFERS

Mr. BUSBEY. Would you, for the record, give us a little of the reasoning back of those transfers?

Dr. VAN SLYKE. The $32,000 transfer to the item "Salaries and expenses, Office of the Administrator, Federal Security Agency," went for part, if not the major support, of an office agent which was set up in Federal Security for aging. It is concerned with the problems of aging—not only the health problems but the economic and welfare problems of aging.

The $2,000 that went to "Salaries and expenses, Office of the General Counsel, Office of the Administrator, Federal Security Agency," was a proportionate charge of the National Heart Institute for the additional legal counsel that we needed this year.

The $191,000 represents a transfer of grants from the Heart Institute to the National Institute of Neurological Diseases and Blindness. These research projects were supported previously in the National Heart Institute; but, because of the close interdigitation of neurologic control—and by "control" I mean nervous control—in those research grants, they probably more properly belong in these other institutes.

COOPERATIVE RESEARCH ON PROBLEM OF AGING

Mr. BUSBEY. How did the problem of aging get into the National Heart Institute originally?

Dr. VAN SLYKE. We have accepted in the National Heart Institute the problem of aging as part of our activities, because the type of degenerative heart diseases is a very common finding in older persons, and the aging of tissues is important to us who are concerned with the cardiovascular system which permeates the entire body and is of considerable concern to us in getting as much information in this field as we can to enable us to better attack the total problem of cardiovascular diseases.

I might at this point, although it will be introduced in the record according to your instructions yesterday, point out that we intend to continue over at the Baltimore City Hospital our unit on gerontological diseases when the clinical center is opened. I particularly stress that now because here we have a group of patients whose care in ordinary hospitals is not a function of the Federal Government, and this gives us a double opportunity to carry out necessary research at the most economical level. That, incidentally, means at a place like Framingham where we have a group under observation and in continuing them for many years they will also be included in the research which the National Heart Institute will continue.

Mr. BUSBEY. Why is this work not done in the Mental Health or other institutes?

Dr. VAN SLYKE. The work on aging?

Mr. BUSBEY. Yes.

Dr. VAN SLYKE. It is. The Mental Health Institute is concerned with the problem of aging, and we have set up with them at the Balti-

more City Hospital a cooperative direct research study because of the interdigitation of interest in that area.

Mr. BUSBEY. Is there any other institute besides the Mental Health Institute interested in the problem?

Dr. VAN SLYKE. Not right now, although I would say in reporting fully to the committee that there probably will be others, particularly in the field of neurological diseases, on the problem of rehabilitation.

Mr. BUSBEY. We had the mental institute under consideration this morning, and I do not recall that there was any transfer of funds for this work on problems of aging, was there, Mr. Harlow?

Mr. HARLOW. No; there was not.

Dr. VAN SLYKE. No, sir; there was no transfer of funds. This I am talking about is a cooperative project without any transfer of funds.

BUDGET FOR CLINICAL CENTER ACTIVITIES

Mr. BUSBEY. How much of this requested appropriation is directly attributable to the opening of the new clinical center?

Dr. VAN SLYKE. $675,100 is the net increase in the appropriation.

RELATIONSHIP OF REHABILITATION WORK TO REHABILITATION PROGRAMS OF OTHER AGENCIES

Mr. BUSBEY. On page 138 of the justifications it is stated:

> Important consideration will be given to projects pertaining to rehabilitation of persons handicapped by cardiovascular diseases and the problems of arteriosclerosis and rheumatic fever will receive special attention.

That is in the field of rehabilitation, and it seems that FSA has projects in this field under a great many appropriations. Will you tell us about your work and how it is related to the work of vocational rehabilitation, hospitals and medical care, assistance to States, general, and the others in this field.

Dr. VAN SLYKE. The first thing I should like to say to the committee is the fact that we do not deal in services to people; these are research projects on how best to rehabilitate people who become afflicted with cardiovascular diseases, particularly with a failing heart, a heart stroke, or coronary thrombosis, or those people who have rheumatic fever and thus are very subject to the development of rheumatic heart disease. I particularly stress this is not a service program; this is a research program on how best to do the job. It represents only a relatively small portion of the funds which are appropriated to the National Heart Institute for the support of research projects.

TEACHING OF MEDICAL SUBJECTS

Mr. BUSBEY. I also notice you are contributing to the field of rehabilitation under your program "Teaching of medical subjects" covered on page 139 of the justifications.

Dr. VAN SLYKE. Yes, sir.

Mr. BUSBEY. Will you tell us about that, briefly?

Dr. VAN SLYKE. A thing we find is our greatest stumbling block in developing a national program of rehabilitation is the fact that there are so very few persons competent to teach in this field. Thus, because of the tremendous interest in rehabilitation of the National Heart Institute—and I might digress there and say, if a person gets a stroke, unless he gets under proper and rather prompt rehabilitation

exercises, he can be a hopeless cripple for the rest of his life; he can get a frozen shoulder cradle just by lying in bed, and if he can just get a pulley and a piece of rope so that he can pull his bad hand with his good hand, keep that shoulder from being frozen. That is the type of interest we have in rehabilitation. We are not going to be able to spread the concept and knowledge of rehabilitation until we have a group of adequate persons competent to teach in this field. Right now there are relatively only a handful of persons competent to take on that job. So this program in the field of grant area is aimed at developing these leaders and teachers in this field of rehabilitation.

FINANCING OF WORK ON AGING

Mr. BUSBEY. I don't believe that you gave us an explanation as to why the mental health part of the program on aging is not being transferred to the Administrator's Office whereas the heart institute part is.

Dr. VAN SLYKE. I think I have clumsily led you and the committee astray in my report on that. There is no transfer of funds involved. It merely means one of the scientists on the mental-health-research staff is working with our scientists at this gerontology unit in Baltimore. There is no transfer of funds involved; it is purely a cooperative research endeavor.

Mr. HARLOW. I think, if I may supplement your statement a little bit, Dr. Van Slyke, there is this proposal to reduce the heart appropriation by $32,000 and transfer it to the Office of the Administrator. But there will still be in the Heart Institute a lot of programs which have connotations in the aging field. It is only the financing of this particular organization that has been set up in the agency, which we are now paying, which is being transferred into the Administrator's own appropriation.

Mr. STEPHENS. I can supplement that still a little more. About 2 years ago the agency had a conference on aging. Then they decided to draw in some people to do some studies on geriatrics, a study known as aging, and they started that off with a man in charge whom they got from Public Health and made Public Health continue to help pay for it. And since so many units in the agency like Public Assistance, Old Age and Survivors Insurance, and Public Health, and even a little in Education concerning aging, those people were more or less assisting or contributing their part over a year and a half or two years, and last year Mr. Fogarty admonished us that instead of running a little show like that and tapping units to pay for it as an admirable and essential part of the program, we should put the money for that in the Office of the Administrator's appropriation. In order to get it over there where it is now, these people would have to get credit for it, as it was taken out from theirs and put in over there. That is exactly what happens in this year's budget.

MENTAL HEALTH SHARE OF PROGRAM

Mr. BUSBEY. Then we are brought back to the question of why mental health is not handled in the same way.

Mr. STEPHENS. Yes, sir. That is a very logical question. But up until this budget was made the Mental Health people had not in fact contributed financially to this program. They did have some of their

own work going on, but they had not contributed any financial or physical support to this activity. There was not anything in there to take out and put in the Administrator's budget. There was, and I think you will find throughout the Agency's appropriations maybe in 2 or 3 places where the aging money came from. It was transferred from other units that had been supporting aging, over to the Office of the Administrator's budget, so that when you look at the Office of the Administrator's budget it is all of the aging money. Portions are no longer being supported and paid for by other units of the agency. This year they are all in the aging unit. In other words, the Administrator's office aging budget will show up as a legitimate item in that budget instead of being scattered all around in other places.

Mr. BUSBEY. Thank you, Mr. Stephens.

RECENT DIAGNOSTIC AND TREATMENT DEVELOPMENTS

Mr. FOGARTY. Doctor, according to your report, you have made some definite progress in the diagnosis and treatment of diseases of the heart since this Institute was started 4 years ago.

Dr. VAN SLYKE. Yes, sir; very definitely.

Mr. FOGARTY. What are some of the things that have been developed in the past year that we can look to with hope?

CLEARING FACTOR

Dr. VAN SLYKE. I think probably the most important thing is the development of this clearing factor I spoke about. I won't go further into the technical aspects of it.

Mr. FOGARTY. What does it do?

Dr. VAN SLYKE. By this research work, if we can get in relatively pure forms the four components of the blood stream that are involved, if this research work goes ahead and we reasonably can hope it will and do expect it will, it will give us, first, a test which can be broadly applied throughout the country for the early detection of hardening of the arteries or arteriosclerosis. Secondly, if we can draw logically from our present conclusions that we are able to determine which of those factors have to do with the presence of abnormal fat-protein molecules in the blood, then we should be able to supply the missing factor so that people do not develop hardening of the arteries. It is pretty comparable to some success that people in the field of diabetes have had by giving insulin. You may have to take a medicinal every day. We do not know. This is not an accomplished fact. I may have to come back to this committee in 2 or 3 years and say our balloon has burst, but right now it looks extremely reasonable. If it is all we hope, it will have a protective impact on the health of our citizens; it will also have a tremendous impact on many of those people Dr. Felix referred to who are incarcerated at present in mental hospitals because of hardening of the arteries.

Mr. FOGARTY. What else has been done?

OTHER DEVELOPMENTS

Dr. VAN SLYKE. As we reported to the committee last year, we have continued our work on the short-acting anesthetics to improve their safety, so that persons with heart disease could more safely take an anesthetic.

We have continued our work, essentially applied work, on the use of procaine amide for the avoidance and cure of cardiac irregularities which, particularly in association with heart stroke, are many times fatal and we know now preventable.

We have continued our fundamental work on the causes of heart failure, congestive heart disease, and as I reported in my prepared statement, we find there is a relationship between the state of vessels and substances derived from the liver which we had not previously known about. I think it is an important building block in our sum total of knowledge to combat the cardiovascular diseases.

We have, of course, continued our experimental research on instrumentation in the cardiovascular field. Besides the electrokymograph which you brought to the attention of the committee yesterday, we have continued to work with a machine which deals with the transmission of a pulse wave down a vessel so that we can determine from the characteristics of that pulse wave what is the character of that artery. It is extremely important not only in the field of cardiovascular disease per se, but I think can be important in certain metabolic diseases, possibly, as in the case of diabetes, where a partial occlusion of the vessel may be responsible finally for an amputation being necessary.

SURGICAL TECHNIQUES

Mr. FOGARTY. Have any new surgical techniques been developed in the past year?

Dr. VAN SLYKE. Yes. We are pleased to report since we were here a year ago that the heart-lung machine has been perfected, and the heart part of it, the pump, has been used many times successfully in humans, and we think we now have licked as far as we can tell from work on experimental animals, the lung side of it. This will never be a routine instrument at any time, but in research centers and special centers we should be putting to practical use this heart-lung machine so that surgeons can do adequate heart surgery in the so-called dry areas where they do not have bleeders. They can then do types of surgery that they could not dream of doing now.

Mr. FOGARTY. Is that what is referred to sometimes as the mechanical heart?

Dr. VAN SLYKE. That is right—the mechanical heart plus the lung. The lung part provides aeration of the blood and keeps it sterile and keeps it from foaming and gets rid of the carbon dioxide. The heart pump itself is not nearly as complex as the two added together. And it is extremely important because we have to short circuit the lungs in some way if we really want a totally dry heart; otherwise you will have fluid in the heart cavities.

I think another thing of interest and probably of special interest here in the National Capital is that Dr. Hoffnagle has put into a person an artificial heart valve, the aortic valve, and this person, instead of being bedridden with a head that jerks back violently with each beat of the heart, is now up and around earning her living as a result of this type of surgery.

Mr. FOGARTY. There are some types of operations you can perform now on the heart that you could not perform 3 or 4 years ago.

Dr. VAN SLYKE. That is right, Mr. Fogarty. I have a very good friend whose wife was incapacitated by a heart disease and who could never get off the first floor. Now, by the new type of heart surgery

which is available she is leading, so far as we can tell, a very normal life, taking care of her family and housework, and she is completely happy.

Mr. FOGARTY. I remember that Dr. Blades, of George Washington University, last year testified about some work he had just done on blood vessels.

Dr. VAN SLYKE. Blood-vessel grafts.

Mr. FOGARTY. Yes. Is that progressing?

Dr. VAN SLYKE. That work is progressing; yes, sir, and progressing very satisfactorily. That, of course, is of extreme importance. I had better stop and explain "that" first.

By "that" I mean the replacement of blood vessels by vessel grafts. In the field of military operations, in ordinary accidents, and in industry it is necessary sometimes to be able to replace a segment of a vessel or you will lose a limb. It is just that. If you get shot through the arm and you sever the main artery, unless you can replace that segment of the vessel there is a very good chance you will not have any forearm or hand at all. From the elbow down will have to go, because there will be no blood circulating.

The same thing is true in the thigh, between the hip joint and the knee. If you catch the femoral artery you can now replace it if the segment needs to be replaced. You do not have to lose the limb below, because of a lack of blood supply.

Mr. FOGARTY. I understood him to say a year ago that this work was done under a grant from the National Heart Institute.

Dr. VAN SLYKE. Yes, sir.

Mr. FOGARTY. Which enabled him to work on this project.

Dr. VAN SLYKE. I think that should give the committee a lot of satisfaction. It was through your efforts that these funds were made available for this purpose.

OPERATION FOR HIGH BLOOD PRESSURE

Mr. FOGARTY. Has this operation for high blood pressure gotten to the point now where it can be considered a successful operation?

Dr. VAN SIYKE. It is a successful operation, Mr. Fogarty, in selected patients. Why not all patients will respond to it we do not know, but we have preoperative tests which indicate fairly well which patients will respond satisfactorily and which ones it is inadvisable to do it on.

Mr. FOGARTY. In other words you can tell now, where you could not just a few years ago, whether a person is going to respond to that type of operation or not.

Dr. VAN SIYKE. That is right.

Mr. FOGARTY. Or what his possible chances are of surviving.

Dr. VAN SLYKE. Yes, sir. One of the unfortunate results of this type of surgery, before we had this research which developed adequate preoperative tests, was that after the operation the patient was practically bedridden, because the minute he tried to sit up or stand up the blood all drained to the dependent parts and the person would just faint right dead away.

RHEUMATIC FEVER AND HEART DISEASE IN CHILDREN

Mr. FOGARTY. When you referred to heart diseases in children from the ages of 5 to 14, did you refer to rheumatic heart disease or rheumatic fever?

Dr. VAN SLYKE. Yes, sir; rheumatic heart disease. Rheumatic heart disease follows on rheumatic fever. It very seldom develops at the time of the acute attack. But in children that is the time it is most likely to develop. A child with acute rheumatic fever is apt to develop rheumatic heart disease at a later time.

Mr. FOGARTY. Is it possible to prevent rheumatic fever in children at the present time?

Dr. VAN SLYKE. Yes, it is. It is one of the bright lights or one of the leading stars on our horizon, to which we are aiming. That is to get people who have had rheumatic fever to take treatment. Rheumatic fever tends to recur from time to time. These recurrent attacks of rheumatic fever are what cause rheumatic heart disease. It is our aim to get people with rheumatic fever to go on a scheme of prophylaxis; that is, by taking one of the sulfonamid drugs or penicillin daily over a period of years, so that they can prevent recurring attacks of streptococcal infections and so rheumatic fever. This means, gentlemen, the prevention of rheumatic heart disease. The type of disease that kills at 35 or 40, right in the prime of life, is rheumatic heart disease.

NEED FOR HEART DISEASE RESEARCH

Mr. FOGARTY. Heart disease today is the leading cause of death; is it not?

Dr. VAN SLYKE. Yes, sir.

Mr. FOGARTY. More people today die of heart disease than of any other disease?

Dr. VAN SLYKE. Yes, sir. It is something over three-quarter million persons in the United States.

Mr. FOGARTY. This has been going up over the years?

Dr. VAN SLYKE. Unfortunately that is so.

Mr. FOGARTY. One of the reasons is because our population is living longer than it did 10 or 20 years ago.

Dr. VAN SLYKE. I think so. The total numbers, of course, Mr. Fogarty, result from the increase in population, but that does not account for the total increase. There is an actual besides an evident increase in heart disease.

Mr. FOGARTY. But it is not necessarily true that you have to be 60 years of age before you can suffer a heart attack?

Dr. VAN SLYKE. Oh, no.

Mr. FOGARTY. I keep reading in the papers of men who are in their 40's who are dying of heart attacks. Unfortunately, many of them did not know they had any symptoms at all.

Dr. VAN SLYKE. What you say is unfortunately the truth. Though more of it occurs in the older age groups, at any time almost from birth up you can expect heart disease. Of course, it becomes more and more prevalent after the age of 25. Sudden deaths of people 30, 35, and 40 are common.

Mr. FOGARTY. Are there any data available on the reasons people between 30 and 50 suffer these attacks; whether because of emotional upset, overwork, or undernourishment?

Dr. VAN SLYKE. Mr. Fogarty, I would say that we do not know the exact reason. We can tell it results from atherosclerosis, a type of hardening of the arteries, but that really is not answering the question at all.

The only way we can answer the question of what causes atherosclerosis is to tackle it through basic research. I have already given you a lead today, gentlemen, with relation to this clearing factor, which apparently has a definite relationship to the production of atherosclerosis.

I would like the record to show very plainly that this is in terms of a scientific report, a premature statement, though it is reasonable to express our hopes this way to the Committee: If this research stands up then we stand on the threshold of doing a tremendously big job in heart disease. We do not expect, Mr. Chairman, for people to live beyond their allotted span of time, but we are tremendously interested that they spend their alloted span of time in good health. As a matter of fact, so far as I can see as a person not very competent in the field of economics, it seems like a poor dollar bet not to keep these people as healthy as we can.

Mr. FOGARTY. Doctor, you are no longer the head of the Heart Institute, are you?

Dr. VAN SLYKE. No, sir.

NEW DIRECTOR OF NATIONAL HEART INSTITUTE

Mr. FOGARTY. Who has taken your place?

Dr. VAN SLYKE. Dr. James Watt.

Mr. FOGARTY. Is he here?

Dr. VAN SLYKE. No, sir. Dr. Watt has just taken on the responsibility of Director of the Heart Institute.

Mr. FOGARTY. Who was he? Where did he come from?

Dr. VAN SLYKE. He is a regular officer in the Public Health Service. Today, unfortunately, he is in New Orleans because of a serious illness of his wife, an emergency operation which came up.

FINANCING OF COOPERATIVE WORK ON AGING

Mr. FOGARTY. There is one thing I want to mention, on this Committee for the Aging.

I remarked a year ago, Mr. Chairman, that there were some positions in the Office of the Administrator which were being paid for out of other agencies or by transfer funds from other agencies in the Public Health Service. I think they said at that time that the Committee had just been established and they were spending about $70,000, but it did not show in the Office of the Administrator. That is why we brought it out.

I think Mr. Stephens was correct in that we said at that time that, if there were a certain number of positions in the Office of the Administrator, we ought to know who they were and why they were there and what they were working on. That is why we discussed it, in that light, a year ago, and asked them to get them together and show us in one place just what they were doing.

Mr. BUSBEY. I think that is correct, Mr. Fogarty. I believe those positions will be shown in the Office of the Administrator in the 1954 budget; will they not, Mr. Stephens?

Mr. Fernandez?

Mr. FERNANDEZ. No questions, Mr. Chairman.

Mr. BUSBEY. Thank you very much, Dr. Van Slyke.

Dr. VAN SLYKE. Thank you, Mr. Chairman.

TUESDAY, MARCH 31, 1953.

DENTAL HEALTH ACTIVITIES

WITNESSES

DR. JOHN W. KNUTSON, ASSISTANT SURGEON GENERAL, CHIEF DENTAL OFFICER

DR. FRANCIS A. ARNOLD, JR., DIRECTOR, NATIONAL INSTITUTE OF DENTAL RESEARCH

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$1,617,654	$1,650,000	$2,700,000
Reimbursements from non-Federal sources	4,144		
Total available for obligation	1,621,798	1,650,000	2,700,000
Unobligated balance, estimated savings	−6,904		
Obligations incurred	1,614,894	1,650,000	2,700,000
Comparative transfer to "Assistance to States, general, Public Health Service"	−9,827		
Total obligations	1,605,067	1,650,000	2,700,000

NOTE.—Reimbursements from non-Federal sources above are from the proceeds of sale of personal property (40 U. S. C. 481 (c)).

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
1. Grants:			
(a) Grants for research and training:			
(1) Research projects	$221,000	$221,000	$564,000
(2) Research fellowships	49,630	50,000	50,000
(3) Construction of research facilities			500,000
2. Direct operations:			
(a) Research	348,618	386,000	579,000
(b) Other direct operations:			
(1) Review and approval of research and training grants	11,430	11,500	11,000
(2) Technical assistance to States	793,708	800,000	800,000
(3) Coordination and development of dental resources	124,292	126,000	126,000
(4) Administration	56,389	55,500	70,000
Total obligations	1,605,067	1,650,000	2,700,000

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Total number of permanent positions	189	207	207
Full-time equivalent of all other positions	7	9	11
Average number of all employees	178	184	199
Average salaries and grades:			
General schedule grades:			
Average salary	$4,219	$4,444	$4,444
Average grade	GS-6.0	GS-6.3	GS-6.3
Ungraded positions: Average salary	$5,060	$5,060	$5,060
01 Personal services:			
Permanent positions	$887,118	$981,958	$1,062,858
Part-time and temporary positions	21,768	29,400	40,700
Regular pay in excess of 52-week base	1,972	2,433	2,433
Payment above basic rates	3,537	3,600	3,900
Total personal services	914,395	1,017,391	1,109,891
02 Travel	96,848	108,950	110,300
03 Transportation of things	18,259	17,200	17,800
04 Communication services	5,019	5,483	6,083
05 Rents and utility services	1,755	4,700	4,700
06 Printing and reproduction	28,247	18,900	19,400
07 Other contractual services	48,465	22,140	22,240
Reimbursements to "Operating expenses, National Institutes of Health, Public Health Service"	81,020	84,700	165,100

Obligations by objects—Continued

		1952 actual	1953 estima e	1954 estimate
08	Supplies and materials	$87, 166	$69, 750	$95, 150
09	Equipment	54, 267	31, 700	36, 700
11	Grants, subsidies, and contributions	270, 740	271, 000	1, 114, 000
15	Taxes and assessments	1, 684	1, 370	1, 920
	Subtotal	1, 607, 865	1, 653, 284	2, 703, 284
	Deduct charges for quarters and subsistence	2, 798	3, 284	3, 284
	Total obligations	1, 605, 067	1, 650, 000	2, 700, 000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$274, 586	$240, 767	$255, 767
Obligations incurred during the year	1, 614, 894	1, 650, 000	2, 700, 000
	1, 889, 480	1, 890, 767	2, 955, 767
Deduct:			
Reimbursable obligations	4, 144		
Adjustment in obligations of prior years	16, 439		
Unliquidated obligations, end of year	240, 767	255, 767	855, 767
Obligated balance carried to certified claims account	1, 185		
Total expenditures	1, 626, 945	1, 635, 000	2, 100, 000
Expenditures are distributed as follows:			
Out of current authorizations	1, 434, 159	1, 450, 000	1, 920, 000
Out of prior authorizations	192, 786	185, 000	180, 000

Mr. BUSBEY. The committee will come to order.

The next appropriation request we have for consideration is for the dental-health activities for the fiscal year 1954. I believe you are going to testify on this, Dr. Knutson?

Dr. KNUTSON. Yes, sir.

Mr. BUSBEY. You may proceed with your prepared statement.

GENERAL STATEMENT

Dr. KNUTSON. Mr. Chairman and members of the committee; under the item "Dental-health activities" we are concerned with efforts directed toward preventing, treating, and controlling a variety of diseases and abnormal conditions which are hazards to dental health. Among these, the most common—in fact, the most common of all diseases—is dental caries or tooth decay.

HAZARDS TO DENTAL HEALTH

Tooth decay begins early in life. In some areas as high as 50 percent of the 2-year-olds have one or more decayed teeth. By the time children reach school age, more than 90 percent have one or more decayed primary or baby teeth. It is at school age that the permanent teeth begin to erupt into the mouth to replace the baby teeth. Decay in permanent teeth starts early too and increases yearly, so that more than 95 percent of our children aged 15 years have 1 or more decayed permanent teeth, and the average per child is about 9 decayed teeth, of which 2—and these are now permanent teeth—have already been lost due to neglect or lack of treatment of the decay. Following in the wake of tooth decay, of course, is toothache, infection, and loss of teeth; so that currently it can be predicted that the average adult will have lost half of his teeth by the time he reaches the age of 40.

Diseases of the supporting tissues of the teeth, periodontal diseases or pyorrhea, are also extremely prevalent as a hazard to dental health. It is estimated that about one-third of our 30-year-olds have some signs of pyorrhea and that the prevalence increases with age, so that as high as 85 percent are ultimately afflicted with this baffling dental disease—the one which is the major cause of tooth loss in adults.

A third major hazard to dental health is malocclusion, a condition in which the teeth are either improperly arranged in the jaws or where there is a malrelationship between the teeth or the jaws to each other. The severity may range all the way from the extremes of the "Andy Gump" to the "Pop Eye, the Sailor" type of jaw relationships. In other words, the condition may vary from a mild one, from the viewpoint of function and appearance, to an exereme case with obvious facial disfigurement where function is very low. However, loss of function is of less importance to the individual than the problem of social adjustment and mental hygiene. In approximately 1 out of every 10 children dento-facial deformities are serious enough to warrant treatment through orthodontic care services.

A fourth major hazard to dental health is harelip and cleft palate. It is the most common of all congenital defects and occurs once in every 800 live births. When untreated, this condition results in a serious disturbance in the basic mouth functions of eating and speaking and in facial disfigurement of grave importance. Remarkable progress has been made in the handling of these cases and the modern procedures employed involve teamwork which includes not only the dentist but the oral surgeon, the speech therapist, the psychologist, the orthodontist, the prosthodontist, and the pediatrician. Unfortunately, only a small proportion of those afflicted with this condition now come under the surveillance of a team such as I have mentioned.

The fifth and last hazard to dental health which I shall mention here is oral cancer. Almost 15 percent of all cancer in males occurs in or contiguous to the mouth—and about 3 percent of that occurring in females. This is important from a dental standpoint since dentists must play the important role of early detection and diagnosis so that the patient may be brought to treatment at the most effective time.

PREVENTIVE MEASURES

Now, what can be done to prevent or eliminate these hazards to dental health? What is being done? Admittedly, with the exception of oral cancers, these are not diseases or conditions which are conceived of as mortal. Rather, they are diseases or conditions which, as has been indicated, interfere with or appreciably reduce the normal functions of chewing, swallowing, and eating, the functions of speech, and in varying degrees from mild to serious extent they affect the facial appearance, social adjustment and the mental health of individuals. Toothache, for instance, is not mortal but can be extremely painful and very annoying. Perhaps the impact of these groups of diseases can best be expressed in terms of what the American people are and are not doing about them.

DENTAL CARE SERVICES

First, the American people are spending approximately $1 billion a year for dental care services. This means that $1 out of every $8 spent for health services is spent for dental health services. The

Federal Government is expending appreciable sums in this area too. It is spending annually now approximately $50 million to provide dental services for the Armed Forces; and it is spending approximately $40 million a year to provide dental services for veterans of World War II. So, the dollar expenditures by the American public and by our Federal Government give us some indication of the impact of the hazards to dental health which I have enumerated.

RESEARCH AND DEVELOPMENT OF PREVENTIVE AND CONTROL PROCEDURES

Now, obviously, the desirable approach, and the only really practical long-range approach to a reduction or elimination of these hazards is through research and the development of effective preventive or control procedures. After all, less than a third of the American people are now getting adequate care services in spite of the $1 billion annual expenditure referred to.

DENTAL RESEARCH ACT OF 1948

Approximately 5 years ago it appeared that at long last our efforts could be directed toward research in a measure more nearly commensurate with the problem. This hope came in 1948 with the passage of the National Institute of Dental Research Act by the 80th Congress. However, as the budget before you indicates, material signs of the success of this effort are hardly perceptible.

The intent of the act is logical and sound. It provides first for fellowships so as to augment the scientific personnel potential of the Nation; second, it provides for grants of funds to research institutions for carrying out dental research projects; and, third, funds are authorized for the support of intramural dental research within our own National Institutes of Health. The authorization is sound but implementing appropriations have been extremely limited. These limitations might better be expressed relatively by the fact that less than 1 percent of the funds appropriated for medical and biological research are earmarked for dental research purposes. Furthermore, less than one-tenth of 1 percent of the money being expended by the American public for dental care is being expended in efforts directed toward eliminating the need for that care, or eliminating the diseases or conditions or hazards which produce the need for that care.

RESEARCH PROBLEMS

In a large part, it is the results of the small amount of dental research now going on that has sharpened our focus on the limitations of dental research itself. For example, the use of the electron microscope in the study of the basic tissues of the teeth, that is, enamel and dentin, has demonstrated that there is a fine submicroscopic network of organic fibrils throughout the enamel—fibrils of protein or soft tissue material. This finding clearly indicates that our knowledge of the principal structures of teeth is far from complete.

Limited studies on periodontal diseases, or pyorrhea, have brought us to the point where it is conceded that infection is secondary to a noninfective factor. Just how this noninfective factor operates, however, no one knows. Nevertheless, there are promising guidelines for a search for more knowledge in this field. It is apparent now that the search must be directed toward elucidating the processes that

govern the activities of tissues, especially the chemistry and physiology of the cell—histochemical studies concerned with the role of nucleic acid in the economy of the cell, and the role of enzymes in cell division. This need is clear from the evidence that there is a basic disturbance in the metabolism of nucleic acid in inflammatory tissue such as we have in pyorrhea.

Similarly, in the field of dental bacteriology it is now realized that much more research is needed to unravel the amazingly complex interrelations of the oral microflora. We know that literally hundreds of different microorganisms exist in the oral cavity either as transients or as permanent dwellers. We know that the activities of these organisms individually may be for good or bad when considered independently. However, it is now quite apparent each may be greatly affected by the enzymatic activities of each of the other microorganisms in the immediate environment. We need to explore and analyze these relationships.

Earlier I indicated the importance of the congenital defect known as cleft lip and palate. Although I referred to the progress made in modern treatment of these cases, basically the crying need is for studies which will lead to a reduction in the incidence of these defects. Recently, under one of our grant-supported projects, it was shown that when female rats are kept on a diet deficient in that important constituent of vitamin B known as riboflavin, one-fourth of their offspring were born with skeletons that are abnormal in one way or another. A high proportion of these abnormalities consisted of cleft palates. Here then is an indicator or a lead which if appropriately pursued may result in the development of a simple preventive technique for successfully resolving the problem created by the major dental health hazards listed as malocclusion, cleft lip and cleft palate.

In fact, all of the foregoing examples point to the tremendous gains that can be made possible through dental research provided reasonable support is given to carry out such research. Specifically, that support must be translated into scientific workers—not only dental scientists but histochemists, enzymologists, physiologists and others directing their attention to the cell and the environmental factors which contribute to health of the cell. Scientists of high competence in these specialized fields must be attracted to dental research in order to continue to build on that knowledge which has already been made available. The basic problem here is one of establishing a solid foundation of support with reasonable assurance of a continuation of that support.

RESEARCH ACCOMPLISHMENTS

I have referred to some of the accomplishments in dental research which point to the need for further investigations. The most outstanding accomplishment in dental research, of course, has been the demonstration of the health-giving values of fluoridated drinking water. This is the most remarkable preventive that has ever been developed in the history of preventive dentistry. Reduced to its simplest terms, this research demonstrated that all drinking water contains some fluorides, but the fluoride content may be too little or too much, or it may be at an optimum level from a dental health viewpoint. Much of the basic work in developing this preventive was begun in 1931 by Dr. H. Trendley Dean who until recently was Director of our Institute of Dental Research.

The initial work in this area consisted of observations on dental caries experience or tooth decay experience in communities having different amounts of fluoride in their drinking water supplies, then extensive animal work, and finally, the pilot program operation in Grand Rapids, Mich., which has been in operation since 1945. This operation consisted of adding 1.0 part per million of fluoride to the drinking water supply. During the 8 years of its operation it has brought about a two-thirds reduction in the tooth decay of those children who have used Grand Rapids fluoridated water since birth. This result and those of similar studies conducted independently in New York, Wisconsin, Texas, Idaho, North Carolina, and Illinois led to the endorsement of fluoridation as a standard public health procedure for preventing tooth decay.

DISSEMINATION OF RESEARCH RESULTS

This brings us directly to the problem of insuring efficient use of sound preventive methods. For example, two well-established dental caries preventives are fluoridation of public water supplies and topical applications of sodium fluoride. Fluoridation has the endorsement of virtually all national organizations concerned with health. Forty-three State health departments have adopted positive water fluoridation policies. Nevertheless, water fluoridation to reduce tooth decay by 65 percent is being used by only 350 water treatment plants serving 675 communities. This is roughly 2 percent of the public water supplies in this country which are fluoride deficient. A shortage of skilled personnel is slowing progress in this field. However, we are doing our best to alleviate the situation by providing limited technical assistance to aid States in the establishment of their own fluoridation services.

We are continuing to encourage the establishment of local preventive and control programs for children unable to benefit from water fluoridation because of their dependence on private wells for drinking water. The emphasis here has been directed to the dental health of that two-fifths of our population living in rural or farm areas.

In carrying out the foregoing activities we are guided by studies specifically designed to improve methods for the prevention and control of dental diseases. These include field studies on fluoridation and defluoridation of public water supplies; clinical studies on the effectiveness of topical agents for dental caries prevention; surveys on the dental needs of children; a determination of the basic principles of sound community organization for establishing and maintaining dental programs; administrative research on dental program operation; and studies concerned with effective utilization of auxiliary personnel.

UTILIZATION OF DENTAL MANPOWER

We are concerned too with the task of investigating, studying, and testing methods for the best use of existing dental manpower. Basic to these efforts is knowledge of the educational and economical factors which enter into dental training and dental practice. A recently published report of a study of dental schools conducted in collaboration with the American Dental Association is our first step in this direction.

Other studies indicate that a dentist can double his output of services and at the same time increase the quality of his services through the effective utilization of chairside assistants. Studies relating to dentist

productivity have also been concerned with the utilization of dental-office facilities and with the design of equipment for efficient dental practice.

This statement attempts to highlight the problem of dental health and the methods and procedures that can be used to resolve the problem. It refers to some of the things the Public Health Service is now doing to contribute to this effort and to some of the many things remaining undone.

If there are any questions relating to this item which I might answer, I shall be glad to try to do so.

TREATMENT OF PYORRHEA

Mr. BUSBEY. You mentioned pyorrhea in your statement. Has there not been some method of treating pyorrhea developed which has at least partially eliminated that problem?

Dr. KNUTSON. Mr. Chairman, I do not know of any method of treating pyorrhea that has been accepted as a cure-all for the disease.

Mr. BUSBEY. Yes; but I believe that there are certain medicines on the market which will cure a certain portion of pyorrhea, are there not?

Dr. KNUTSON. I believe the standard treatment for pyorrhea—that is, early pyorrhea—is the thorough scaling of the teeth, cleansing of the teeth and the exposed root portions of the teeth, adjustment of the occlusion—that is, the biting action of the teeth—so that there is not interference, and inauguration of careful dietary and oral hygiene measures. The therapeutic treatment of pyorrhea is not practiced currently.

STEPS IN SECURING ACCEPTANCE OF NEW TREATMENTS

Mr. BUSBEY. If some individual invented a treatment for pyorrhea, or some medicine to treat pyorrhea, how would he go about getting it accepted by the dentists of the country?

Dr. KNUTSON. I believe he would go through somewhat the same procedures that we have gone through or are going through now in our attempts to bring about the use of such preventive procedures as water fluoridation and topical fluorides. First, the scientific reports or studies would be reported in scientific journals.

Mr. BUSBEY. Who would make those scientific studies?

Dr. KNUTSON. I would say any one of a number of types of investigators; either investigators in the Federal Government, such as we have at our National Institutes of Health, or investigators associated with dental schools, teachers of dental schools who spend part time doing scientific research, or dental clinicians associated with hospitals, or dental clinicians in private practice who have an interest in and give time to dental research.

Mr. BUSBEY. If I had a product which I thought would cure pyorrhea could I come to the Public Health Service and have its scientists make a determination concerning its effectiveness?

Dr. KNUTSON. Yes, indeed. In fact, frequently requests of that type, I believe, are received by individuals in the Public Health Service, at least with the suggestion that they test material which previous tests have indicated has some promise, that they might be effective. That certainly has been true of various topically applied fluorides.

We were not the first to test fluorides topically, but we were among the first. I would say at least a dozen people have tested out the clinical effectiveness of topically applied fluorides for reducing tooth decay. That, I believe, is the ideal way of testing out the effectiveness of such procedures.

Similarly, with water fluoridation. As I indicated, we carried out our studies and tests independent of at least a half dozen other studies designed to determine the effectiveness of water fluoridation. It is pretty well established in scientific circles, particularly in sciences concerned with preventive and treatment measures, that the results and claims of one investigator must be confirmed by others before approval or adoption for general use can be expected.

Mr. BUSBEY. Well, let us say, for instance, that you have tested a cure for pyorrhea and you find it does everything claimed for it. The dentists of the Nation will not accept it until the American Dental Association has put its stamp of approval on it, will they?

Dr. KNUTSON. I am not sure as to just what you mean by that statement.

Mr. BUSBEY. Will the dentists universally accept the findings of the Public Health Service as final and start using that treatment?

Dr. KNUTSON. Oh, no. Nor do they accept the official statements of the American Dental Association; universally, I mean. One hundred percent of the dentists do not agree with what the American Dental Association approves as policy so far as preventive measures are concerned. In other words, it takes time.

Mr. BUSBEY. What has to be done to get an invention or discovery accepted by the dentist if it does everything that is claimed for it by the originating scientist?

Dr. KNUTSON. Well, first, as I indicated, there would be the reports of the tests. Those reports might appear in the Journal of the American Dental Association or a dental research journal or in the Public Health Reports or some scientific journal of that type. Then, perhaps, 1 or 2 other investigators or a half dozen other investigators might take up research on the problem and make similar tests. As research data accumulate there would be an evaluation from time to time of these data.

ENDORSEMENT OF AMERICAN DENTAL ASSOCIATION

The American Dental Association, for instance, if you are thinking specifically of what brings about their acceptance of a preventive, appoints a committee of competent research workers to review the evidence which has been presented for this pyorrhea treatment or for this new preventive measure, to evaluate the data to see whether or not conclusive evidence has been presented.

Mr. BUSBEY. That is not a very easy job, is it?

Dr. KNUTSON. It is not an easy job, no; but that is done before the American Dental Association will officially endorse a preventive or a treatment measure.

Mr. BUSBEY. If some individual in the country perfects something to cure pyorrhea what does he have to do to get the attention of the Institute or the American Dental Association, to get the approval of those groups or in order to get them to test the product?

Dr. KNUTSON. Let me say that individual X felt that he had a medicine which would effectively treat pyorrhea, and he came to me. I would want to see and examine his data, the evidence that he has that it is an effective treatment. I would undoubtedly call in other people competent to evaluate the material submitted. We might ask Mr. X to submit additional information, which he may have or may not have available.

In other words, we would first want to convince ourselves that it looked like a profitable endeavor to test his material or to set up another study to confirm his results, or to find out whether or not someone else had done the work necessary to confirm the results.

As I indicated earlier, certainly today one investigator's work is not accepted. It is not because of the fact that it may not be the correct work, but confirmation of the work is almost always a requirement now. I believe that is right, Dr. Sebrell.

Mr. BUSBEY. It is not an easy or a simple process by any stretch of the imagination, though, is it?

Dr. KNUTSON. No, indeed.

Dr. SEBRELL. Mr. Chairman, if I may supplement what Dr. Knutson is saying, so far as the various research institutes go, this problem of testing various supposed therapeutic substances for all sorts of things is quite a thorny one.

For example, we have hundreds of supposed cancer cures every year that are submitted to us. If a man comes along with a notion or an idea that he has a cure for pyorrhea, cancer, or heart disease, as a rule we will refuse to investigate it. We could dissipate all of our efforts and all of our funds in just fooling with these wild ideas, so we try, with the aid of the National Research Council and with the aid of certain rules we have set up, to require a man who comes up with a supposed cure to submit some sort of evidence with it that will give us an indication of whether it will be worth our while to put money into it.

If it is a real cure you do not have to worry about it getting used. When penicillin came along it was used without any great difficulty. When cortisone came along it was used without any great difficulty. If it is really effective you do not have to do much to get it in use. The men in practice are anxious to have something effective to use.

ADOPTION OF WATER FLUORIDATION

Mr. BUSBEY. Doctor, I notice you state that 43 State health departments have adopted positive water fluoridation policies. Why is there so much opposition to the fluoridation of water?

Dr. KNUTSON. I believe it is the type of reaction that one gets to most new preventive measures, such as water fluoridation. I have been told that there was a similar reaction to attempts to introduce water chlorination back in the early 1900's.

Some of the opposition is based on misinformation. Some of it is based on individuals setting higher requirements, let us say, to approve a new procedure than most of us in the scientific world would set. There are a wide variety of reasons. Frankly, I wish I could understand much of this objection, which is difficult to understand.

The procedure has been called mass medication. I personally do

not see it as mass medication simply because, as I indicated in my testimony, we have fluorides naturally in virtually all of our drinking water supplies. What we are trying to do is imitate nature at its best here and have the right amount, instead of hit-and-miss amounts.

The scientific evidence on the value of water fluoridation is great, and in fact greater than the evidence on the value of any other public health measure. I think most engineers and most Public Health people will readily admit that the actual scientific evidence on the worth of water fluoridation, and its effects, is greater than that on water chlorination, which we have practiced routinely for years.

Mr. BUSBEY. I am certainly not an authority on the subject, but I do read articles in the newspapers and occasionally get some letters in opposition to the fluoridation of water. I just wondered how much of it really is valid.

Dr. KNUTSON. It is a real opposition. Those who are opposed to it apparently, in many instances, are quite violently opposed to it. As I indicated, virtually all the scientific health organizations have approved it, such as the American Dental Association.

The American Medical Association has vouched for its safety and has indicated that a determination of dental benefits must be left to the American Dental Association and dentists, qualified to count cavities. But the American Medical Association has in their survey of the evidence come up with the statement that the procedure is safe.

Mr. BUSBEY. You stated:

> However, we are doing our best to alleviate the situation by providing limited technical assistance to aid States in the establishment of their own fluoridation service.

Specifically, what are you doing to aid the States, Doctor?

TECHNICAL ASSISTANCE TO STATES

Dr. KNUTSON. In my opinion, far too little. This technical assistance is largely limited to assistance rendered by dentists and by engineers who are versed in the technical phases of water fluoridation. That is, they are experts in determining the type of equipment which a community should use, the type of fluoride salt which the community should use, the facilities that need to be added to the waterworks department to fluoridate a community's water supply, and also the techniques for testing fluoride concentration, and the techniques for teaching local waterworks operators to test for fluoride concentration. In other words, they are almost entirely or to a great extent, services which are rendered to States and to communities upon request after communities have decided to fluoridate.

Mr. BUSBEY. In your discussion of tooth decay I did not notice any mention of the effect of ammoniated toothpaste and toothpowder on tooth decay. Is that all it is claimed to be?

Dr. KNUTSON. I am afraid it is not all it was claimed and hoped that it would be. The consensus of dental research workers now, I believe, is that at best, it is of dubious value, and the most recent results of tests have indicated that it is of no value.

1954 BUDGET ESTIMATE

Mr. BUSBEY. Doctor, your request for 1954 is $2.7 million, which is an increase of $1,050,000 over fiscal year 1953; is that correct?

Dr. KNUTSON. That is correct.

DENTAL RESEARCH ACTIVITIES AT CLINICAL CENTER

Mr. BUSBEY. How much of your 1954 request is directly attributable to the opening of the new Clinical Center?

Dr. KNUTSON. $193,000 plus $14,500 are attributable to the opening of the Clinical Center.

Mr. BUSBEY. That would be a total of $207,500?

Dr. KNUTSON. That is correct.

Mr. BUSBEY. Are patients going to be admitted to the Clinical Center just for dental research?

Dr. KNUTSON. Not on the initial opening of the Clinical Center. In fact, it is not within the immediate plans to admit patients specifically for dental disease. The patients who are there for heart disease study or cancer or for other purposes will also be studied for dental conditions. Special dental studies will be made on these patients. It will offer an opportunity to study the conditions previously mentioned, such as pyorrhea. There will be an opportunity to study the effect of dental infections per se, on heart disease and on other diseases of the organ systems of the body. There will be an opportunity to study the effect of X-ray on tissues of the oral cavity. Those are examples of the types of studies that can be made on the patients who will be there for other reasons.

Mr. BUSBEY. The patients will not be admitted to the center just for dental research?

Dr. KNUTSON. Not at the outset. There are no immediate plans for that. That is correct.

Mr. BUSBEY. Is that expected to be done later on?

Dr. SEBRELL. Mr. Chairman, we expect to handle those through the outpatient setup. We do not anticipate the necessity for putting very many of them to bed for dental research. We would have them come in and be seen by the dentists and go back home.

Mr. BUSBEY. Are funds being requested to cover general dental service to patients in the center for other medical research purposes, then?

Dr. SEBRELL. This dental-research activity will cover all the dental service to the patients. Now, we do not see how we can do adequate research unless we go over these patients very thoroughly from every viewpoint. Part of their admission examination or the examinations as they go along will necessarily require an evaluation of the state of their teeth. They may have infections at the roots of their teeth, or various difficulties. We anticipate a large proportion of the patients will require at least a dental examination and possibly some dental treatment in connection with their research on heart diseases or cancer, as the case may be.

Mr. BUSBEY. How would this $207,500 be broken down with regard to your center work?

Dr. SEBRELL. Dr. Arnold is Director of the Dental Research Institute, and has just taken the place of Dr. Dean, who just retired.

Mr. BUSBEY. Do you have a breakdown of that, Dr. Arnold?

Dr. ARNOLD. Yes, sir, Mr. Chairman. $193,000 would be for increased amounts necessary for the full-year cost of conducting clinical investigations in the clinical center under the 18 new positions established in the last quarter of fiscal 1953; and for an increase in reimbursement for central services and for the operation of the institutes as a whole. I think Dr. Sebrell has gone over the operating expenses of the Institutes of Health.

GRANTS FOR RESEARCH PROJECTS

Mr. BUSBEY. You are requesting an increase of 150 percent in research-grant money. Will you tell the committee the reasons for this increase?

Dr. KNUTSON. First of all, we note that the amount that has been available to date for research-grant purposes is very small, $221,000. This is such a limited amount that it has not in any real measure increased dental research that I think was thought of when the National Institute of Dental Research Act was passed. Soon after the act was passed, dental schools and research workers in these institutions submitted research projects to the Public Health Service, to the National Institutes of Health, for grant funds. The amount of funds available for these grants was so limited, however, that only a small portion of them could be approved and money made available for them.

The limited amount of money has seriously affected the types of research project that could even be considered. I mentioned, for example, the importance of cleft lip and palate, the most prevalent of all congenital defects, and how serious this condition is. We have had, as I recall, one request for a grant in this area to do some research on the problem, calling for somewhere around $50,000, but the Advisory Dental Research Council could not give this request serious consideration, because this one project would have taken up all the new money available for grants. So that the limited amount of research funds made available or appropriated has, I think, seriously handicapped dental research in institutions such as dental schools.

VOLUNTARY AGENCIES

Mr. BUSBEY. Has any group of individuals or the public in general become interested enough in research on dental health to organize a private group for this purpose, such as has been done for heart, cancer, arthritis, tuberculosis, and other diseases?

Dr. KNUTSON. Mr. Chairman, there is not an equivalent citizens group, in the field of dentistry such as you mentioned, as there is in the fields of heart disease and cancer.

FUNDS REQUESTED OF BUDGET BUREAU

Mr. BUSBEY. How much did you ask of the Bureau of the Budget?

Dr. KNUTSON. The total of the A and B budgets was $3,720,000.

Mr. FOGARTY. In response to the chairman's question about a similar voluntary agency, such as the American Cancer Society and the American Heart Association, I presume one of the reasons that no

similar voluntary agency has been established for dental matters is because these are not killing diseases, and, therefore, do not attract the attention of people as heart and cancer and many other diseases do.

Dr. KNUTSON. I would agree that would be a logical explanation of why there is not a similar voluntary organization.

WATER FLUORIDATION

Mr. FOGARTY. Doctor, you have been active for some years now in the research on fluoridation of water supply, have you not?

Dr. KNUTSON. Yes; I have been.

Mr. FOGARTY. Were you not instrumental in this work 7 or 8 years ago?

Dr. KNUTSON. My interest 7 or 8 years ago was largely directed specifically to the use of fluorides painted on the teeth, topically applied. Dr. Trendley Dean, and Dr. Arnold here, have centered their attention on the use of fluorides in drinking water.

STATES THAT HAVE NOT ENDORSED PROGRAM

Mr. FOGARTY. What are the 5 States which have not endorsed this program? You say 43 States have.

Dr. KNUTSON. Could I supply that for the record? I know at least three of them are in the southwestern section of the country.

Mr. FOGARTY. Is Nebraska one? Has it endorsed the program?

Dr. KNUTSON. Nebraska has endorsed it. I shall be glad to supply the list of States which have not.

(The information is as follows:)

The States in which there are no approved water fluoridation projects in operation are Arizona, Missouri, Nevada, New Mexico, and Utah.

Mr. FOGARTY. Some of the people who have opposed this program have claimed, although I do not think the claims have ever been proved, that fluoride brings on kidney trouble and other difficulties, have they not?

Dr. KNUTSON. Yes. That is one of the claims. We have studied the data on mortality in the communities where the water has been fluorided naturally for generations, and there is no evidence to support that claim.

COLORADO SPRINGS AND DENVER FLUORIDATION STUDIES

Mr. FOGARTY. In the State of Colorado, there is an excess of fluoride in the water supply of 2 cities. You have been making a study in those 2 cities, have you not?

Dr. KNUTSON. Yes. Colorado Springs, which is a health resort center, and thought of as such, has over two parts per million of fluoride naturally in the water supply. We have studied the data on mortality in that city, and compared them with findings of cities where the drinking water is fluoride free. In the city of Denver most of the water supply contains one part per million. We have studied the data on mortality for those cities. Similar studies have been made in Illinois and Wisconsin.

Mr. FOGARTY. In these two Colorado cities have you found any physically bad effects on the population?

Dr. KNUTSON. None whatsoever. Death rates from kidney disease have been slightly but consistently lower in the cities having the fluoride in the water supply. For heart disease and for some of the other conditions for which some of the opponents of fluoridation make claims, the findings have been in the same direction.

Mr. FOGARTY. From what I understand, those opposing the program have never been able to prove any of the assertions they have made. At the same time they claim that you people cannot prove that it will not affect the kidneys or the heart. Is that not the argument they use?

PROFESSIONAL DENTAL ORGANIZATIONS' VIEWS ON FLUORIDATION

Dr. KNUTSON. Yes. I think it important in this connection that all of the scientific and health organizations previously mentioned have endorsed fluoridation. If there were even one whit of scientific evidence in support of these claims, I am sure these organizations would not endorse fluoridation. So your statement is correct: There has been no evidence whatsoever of any detrimental effect of one part per million of fluoride in drinking water.

Mr. FOGARTY. I am convinced of that myself, and I cannot understand some of these individuals who are still carrying on the fight. Some of them are supposedly medical doctors of long standing and are still opposed.

Dr. KNUTSON. I must agree with you. I have difficulty in understanding most of the opposition.

Mr. FOGARTY. I know the city of Washington, after quite a few years discussion, did adopt it.

Dr. KNUTSON. That is right.

Mr. FOGARTY. I know there was a great deal of opposition to it at that time here. In my own State most of the cities have adopted this program. It has met with universal approval in the State of Rhode Island.

I think it is one of the greatest things the Federal Government has done for the children of the country, especially. Has it not been proven that with the right amount of fluoride added to the drinking water dental decay has decreased by about 60 to 65 percent?

Dr. KNUTSON. That is correct; and that is a very conservative estimate of the reduction, because it is determined on the basis of the number of teeth affected by tooth decay. And not only is the number of teeth decayed reduced by some two-thirds but the extent of the decay in those affected is less where there is fluoride in proper proportions.

Mr. FOGARTY. What are some of the reasons for not adopting the program in most communities?

Dr. KNUTSON. There are a variety of reasons. There is first the opposition, which is quite active in some communities. Then there are other factors; and in my opinion, at least it has been my impression, that there has been more appropriation by the opponents for the fighting of fluorides than by the Federal, State, and local organizations in promoting its use.

COST OF FLUORIDATING WATER SUPPLY

As you have indicated, water fluoridation is a very important discovery, and it is one that should be made available to people as soon as possible, because it is the least we can do, and we can ill afford not to use it. It has been conservatively estimated that for every dollar spent on fluorides there will be a seventyfold to one hundredfold saving in the amount of money required for complete dental care services.

Mr. FOGARTY. After the machinery is bought, the operating costs are not high, is that not right?

Dr. KNUTSON. The operating cost is about 10 cents per person per year.

Mr. FOGARTY. How many demonstration teams have you in operation at the present time?

Dr. KNUTSON. We have no demonstration teams, that is, to demonstrate topical fluorides.

TECHNICAL ASSISTANCE TO STATES

Mr. FOGARTY. What technical assistance do you give to States and the communities now?

Dr. KNUTSON. In general we give technical assistance and consultive services to the States, and these services are rendered locally by the States. Our service is given to the communities only if the States request it be made available to the communities. But all of the services, all of our technical services, are funneled through the State health department; in other words, a request for service must be made by the State health department before we get down to the local level.

A typical unit of technical service personel, available to the States from our regional offices, consists of a dentist trained in public-health procedures, an engineer who is an expert and highly versed in the technical phases of water fluoridation, and the necessary supporting clerical personnel. So you see, we have a rather limited technical staff. The requests for assistance from the technical staff are far beyond our ability to render the services and technical assistance. This is particularly true in relation to the services of a technical or engineering nature in the water fluoridation program.

Mr. FOGARTY. Since this program has the endorsement of the medical profession, perhaps we ought to do more to assist the States in trying to get started on this than we are doing at the present time.

Dr. KNUTSON. There was an item in the original budget request for $3,720,000—a $1 million item for grants to the States to assist them in getting together technical service teams at the State health department level—teams of chemists, sanitary enginers, and dentists to assist communities, and to supply them with technical services in connection with the water fluoridation program.

TOPICAL FLUORIDATION PROGRAM

Mr. FOGARTY. A few years ago we gave you about $3 million over and above the Bureau of the Budget figure to establish topical fluoride demonstration teams to conduct educational programs in the various States, and in my opinion that has paid off.

Dr. KNUTSON. I think it has paid off in many ways.

Mr. FOGARTY. It was a means of getting the program started, as well as a specific method of helping the American Dental Association, and the Public Health Service to get the information together and down to the people.

Dr. KNUTSON. That is correct.

Mr. FOGARTY. And as a result many of these local communities are now carrying on that program and the dentists are doing it at the local level. Do you think the country as a whole would be using it today if we had not stepped in several years ago and appropriated this money?

Dr. KNUTSON. I am convinced that the program was highly effective in bringing about the early use of the topical fluoride procedure on a widespread basis; and incidentally, this is still the only use of fluorides which is available to people in rural communities.

Mr. FOGARTY. The projects that are now being carried on in schools are being carried on through the efforts of the local school authorities.

Dr. KNUTSON. That is correct.

APPLICATION SCHEDULE

Mr. FOGARTY. What is the formula used? It is applied in three applications?

Dr. KNUTSON. Four applications, at 3, starting at the age of 3, and again at ages 7, 10, and 13.

Mr. FOGARTY. And that is all they do?

Dr. KNUTSON. That is correct.

Mr. FOGARTY. That will decrease tooth decay by 65 to 70 percent?

Dr. KNUTSON. The reduction, Mr. Fogarty, is estimated at around 40 percent for topically applied fluorides.

Mr. FOGARTY. It is less for the topical application?

Dr. KNUTSON. Yes; for the other it is 65 percent.

Mr. FOGARTY. There are people in this country who still do not believe in doctors of any kind.

Dr. KNUTSON. Yes.

Mr. FOGARTY. There are certain people who still believe that no doctor can help them if they get ill, and they have opposed this program.

Dr. KNUTSON. Yes.

Mr. FOGARTY. Will you supply for the record the results of the demonstration that you conducted in Woonsocket, R. I., a few years ago?

Dr. KNUTSON. Analysis of the data is not complete, so the results are not ready for publication yet.

Mr. FOGARTY. It is still to be published. Thank you.

TUESDAY, MARCH 31, 1953.

ARTHRITIS AND METABOLIC DISEASE ACTIVITIES

WITNESS

DR. RUSSELL M. WILDER, DIRECTOR, NATIONAL INSTITUTE OF ARTHRITIS AND METABOLIC DISEASES

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate (obligations incurred)			$8,450,000
Comparative transfer from "Operating expenses, National Institutes of Health, Public Health Service"	$4,064,450	$4,626,700	
Total obligations	4,064,450	4,626,700	8,450,000

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
Direct Obligations			
1. Grants for research and training:			
(a) Research projects	$1,346,480	$1,345,000	$2,614,000
(b) Research fellowships	80,090	150,000	135,000
(c) Training stipends	48,000	50,000	150,000
(d) Construction of research facilities			2,000,000
2. Direct operations:			
(a) Research	2,365,454	2,874,000	3,346,000
(b) Other direct operations:			
(1) Review and approval of research and training grants	16,664	17,500	18,000
(2) Administration	125,079	132,400	187,000
Total direct obligations	3,981,767	4,568,900	8,450,000
Obligations Payable Out of Reimbursements From Other Accounts			
2. Direct operations:			
(a) Research	82,683	57,800	
Total obligations	4,064,450	4,626,700	8,450,000

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Summary of Personal Services			
Total number of permanent positions	307	354	354
Full-time equivalent of all other positions	11	13	4
Average number of all employees	294	324	330
Average salaries and grades:			
General schedule grades:			
Average salary	$4,630	$4,857	$4,857
Average grade	GS-6.7	GS-7.1	GS-7.1
Crafts, protective, and custodial grades:			
Average salary	$2,753	$2,719	$2,719
Average grade	CPC-3.1	CPC-3.0	CPC-3.0
Ungraded positions: Average salary	$7,090	$7,169	$7,169
Personal service obligations:			
Permanent positions	$1,493,754	$1,700,015	$1,800,685
Part-time and temporary positions	43,917	52,500	20,700
Regular pay in excess of 52-week base	4,480	5,440	5,440
Payment above basic rates	9,191	2,500	2,500
Total personal service obligations	1,551,342	1,760,455	1,829,325
Direct Obligations			
01 Personal services	1,521,542	1,724,655	1,829,325
02 Travel	28,550	31,000	31,000
03 Transportation of things	7,307	8,800	8,300
04 Communication services	10,562	11,000	11,000
05 Rents and utility services	328	300	300
06 Printing and reproduction	9,596	11,200	12,200
07 Other contractual services	17,121	22,100	18,100
Reimbursement to "Operating expenses, National Institutes of Health, Public Health Service"	646,034	926,900	1,359,300
08 Supplies and materials	194,433	218,092	211,392
09 Equipment	74,459	72,905	72,905
11 Grants, subsidies, and contributions	1,474,570	1,545,000	4,899,000
15 Taxes and assessments	2,975	3,310	3,540
Subtotal	3,987,477	4,575,262	8,456,362
Deduct charges for quarters and subsistence	5,710	6,362	6,362
Total direct obligations	3,981,767	4,568,900	8,450,000
Obligations payable out of reimbursements from other accounts			
01 Personal services	29,800	35,800	
02 Travel	8,425	1,900	
03 Transportation of things	6,708		
04 Communication services	264		
06 Printing and reproduction	22		
07 Other contractual services	4,982	1,500	
08 Supplies and materials	13,657	9,000	
09 Equipment	18,825	9,600	
Total obligations payable out of reimbursements from other accounts	82,683	57,800	
Total obligations	4,064,450	4,626,700	8,450,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Obligations incurred during the year			$8,450,000
Deduct unliquidated obligations, end of year			3,610,000
Total expenditures (out of current authorizations)			4,840,000

Mr. BUSBEY. The committee will please come to order. We have before us the appropriation request for the fiscal year 1954 for arthritis and metabolic-disease activities. Dr. Wilder, I believe you have a statement you would like to make to the committee at this time.

Dr. WILDER. Thank you, Mr. Chairman, and members of the committee. I have a short statement which I will be glad to give to the committee.

GENERAL STATEMENT

I am pleased to acknowledge that this committee has shown continued interest year after year in providing support for medical research in several broad areas. These national-research programs have been of high quality and of a rewarding nature, as you have heard.

What I would like to present today is an outline of plans and intentions in the newly established National Institute of Arthritis and Metabolic Diseases.

The rheumatic and metabolic diseases are well represented among the chronic disorders which are increasingly receiving the attention of medical and allied workers. The successful outcome of the attack against the more acute disorders, such as typhoid fever, has led everyone to expect that comparable efforts directed against the chronic illness will be comparably rewarding. You already are reaping rewards from your investments in heart, cancer, and mental health, and you can expect similar rewards in arthritis, diabetes, and other chronic disease conditions.

True, neither arthritis nor other metabolic diseases rank at the top in terms of death rates, but arthritis is a major cause of chronic crippling of the population. This becomes a serious concern in times like these when maximum use of our manpower potential may be required to meet the dangers facing us.

I have been interested in certain calculations relating to the crippling effort of some of these diseases. Conservative and very independent estimates indicate that 150 million man-days are lost each year because of diseases of the joints. That represents 410,000 persons continuously out of work. The cost to the Nation is at least $725 million a year.

Gentlemen, I recommend an expenditure, on behalf of the American people, of only a small fraction of that amount. I earnestly believe that adequate support of research necessary in this field—perhaps $8 million a year for 20 years—would provide the information as to the cause and prevention of arthritis. That, I submit, is good investment.

The Nation then would save annually the millions now lost in salaries and wages, another 100 million spent for medical care, and additional moneys which now go to pay relief allowances to sufferers from arthritis. The income tax alone on the wages now lost probably would pay for the research program many times over.

RESEARCH EXPERIENCE OF DIRECTOR

My interest in the programs of this Institute is based on long experience both with arthritis and diabetes. It began 40 years ago when I was an intern in the Presbyterian Hospital in Chicago, on the service of Dr. Frank Billings. Dr. Billings then was winning world-wide acclaim for his theory of focal infection, and hundreds of patients with arthritis were coming to him for treatment. At the same

time, I was associated with Dr. Roland Woodyatt, whose studies in diabetes were receiving wide attention. My interest in these two areas of chronic disease continued, and in the course of the many years which I spent on the staff of the Mayo Clinic I have been privileged to be closely associated with two epoch-making discoveries—the discovery of insulin in the early twenties and that of cortisone in 1949.

I was fortunate in being a member of the committee headed by Banting and Best when the then newly isolated insulin first was put to clinical trial and cortisone was discovered in my own clinic by Dr. Kendall, with whom I was intimately associated.

Neither insulin nor cortisone provided a cure for anything, but both in diabetes and in the rheumatic diseases the disability of the victim now can be corrected in a very large degree. Insulin enables patients with severest diabetes, who otherwise would be marked for death, to live out active lives. Cortisone and its related hormones control the pain and swelling of arthritic joints and, when used with wisdom and discretion, give peace and comfort to many sufferers from rheumatic pain and disability.

ESTABLISHMENT OF ARTHRITIS AND RHEUMATISM FOUNDATION

These two discoveries have greatly increased the popular interest in diabetes and arthritis. That interest is growing and is comparable to that which has developed for other chronic diseases, such as cancer and diseases of the heart. We now find a large voluntary agency, comparable to those existing for heart, cancer, and poliomyelitis, devoted to raising funds for the study of arthritis, with chapters widely scattered over the United States and a growing public demand that the National Government undertake support of research and control of these afflictions. We are working closely with the Arthritis and Rheumatism Foundation in order to avoid overlapping of activities. We have helped them where we could and, in return, have received from them advice and consultation. They recently made me a member of their medical and scientific committee.

AMERICAN DIABETES ASSOCIATION

Another organization with a deep interest in our Institute is the American Diabetes Association. This is a group of physicians of which I was president in 1947. I still am a member of their administrative council.

Because of my previous experience, first in Chicago and later at the Mayo Clinic, I was greatly pleased to be asked to have a hand in this Public Health Service attack directed on arthritis and diabetes. We are making progress, although lack of funds has made this progress slower than we would like to have it. It is our misfortune to have been established just as the Korean episode led to retrenchments all along the line. Biological research is regarded as of civilian rather than military importance. This, I think, is a mistake. Actually, returning to the calculations to which I referred earlier, our military manpower loss because of rheumatic diseases alone is considerable—6 percent of all Army rejectees. In the last 500,000 examinees that means 30,000 rejectees, or 2 infantry divisions. I must admit a personal feeling that excessive economy at the expense of the public health is not

necessarily in the best public interest. The statistics I have quoted show that there is a big job to be done, and to do it wrong will cost more money in the end, much more indeed, than it takes to do it right.

My interest in undertaking the direction of the National Institute of Arthritis and Metabolic Diseases—and I might add here that I was able to do this because I reached retirement age in the Mayo Clinic, 65, and was freed from my responsibilities there because of that—my interest in undertaking the direction of the National Institute of Arthritis and Metabolic Diseases was also based on what I considered to be a very fortunate opportunity to include in this Institute several of the previously existing basic science laboratories of the National Institutes of Health. These four laboratories of chemistry, biochemistry, biophysics, and pathology provide us with the solidity of scientific understructure so essential to successful study of any disease.

I have also long been interested in public health and in the researches of the Public Health Service; that has been one of the great interests of my life, since my work with typhus with Dr. Howard Ricketts, in Mexico City, in 1909 and 1910.

I have also watched Dr. Sebrell's work, and the other doctors with whom I am associated since coming to the National Institute of Health, and have been interested in this activity all of my life.

So, I was very proud to have an opportunity to be connected directly with these four laboratories. Much of the work done in these laboratories applies directly to the better understanding of the diseases in our area of interest. If you have time later, I should like to speak about a number of the recent achievements of these laboratories.

PERSONNEL AND WORK OF INSTITUTE

We intend attacking more directly in the area of rheumatoid arthritis, gout, and diabetes with the staff of our new clinical division. This will operate in the space assigned to us in the clinical center. Heading the studies of arthritis will be Dr. Joseph J. Bunim, who came from an associate professorship in the New York University Medical School where he had been engaged, with Dr. Currier McEwen, in research on rheumatoid and other forms of arthritis and in developing and conducting the most effectively organized arthritis clinic in the world.

Much of the work in the laboratories is to provide information that may prove to be extremely valuable in the attack on arthritis and diabetes. When the work first starts, you cannot be sure what the outcome will be. When the work was first started on cortisone in the Mayo Clinic, we supported it for years without apparently seeing any results. We had no thought that it would result in a treatment for arthritis or for the many other diseases in which it has been useful. You never know with research when it will result in something that is extremely valuable and practicable.

And, as I say, heading the studies of arthritis will be Dr. Joseph J. Bunin, who was an associate professor in the New York University Medical School, and who was engaged with Dr. McEwen in research work on rheumatoid and other forms of arthritis, and in developing and conducting the most effectively organized arthritis clinic in the world.

Mr. FOGARTY. Where is that?

Dr. WILDER. At the Bellevue Hospital in New York. I feel very fortunate in having him with us.

Heading another branch of our clinical investigation is Dr. G. Donald Whedon, who came from the Russell Sage Nutrition Laboratory. Its fame is worldwide because of the studies of energy metabolism there of Dr. Eugene DuBois and his associates. Dr. Whedon will have a respiratory chamber and a calorimeter, and, with these facilities, will study energy exchange in a variety of diseases. A collaborative investigation of this nature will be made on cancer patients with the Cancer Institute.

In Dr. Whedon's calorimeter chamber persons can be kept for as long a period of time as desirable, with every bit of the air that he breathes analyzed, the amount of oxygen intake and the amount of carbon dioxide lost, measured continuously. It is expected that these studies will help in solving many problems that remain unsolved.

And, as I stated, the collaborative investigation of this nature will be made on cancer patients at the Cancer Institute, and we are making plans for that right now.

Dr. Whedon also has an interest in diseases of the bones, and he and his associates will be concerned with skeletal diseases. They relate to some extent to diseases of the joints.

We already have a group of scientists working with the endocrines, the glands of internal secretion, like the thyroid and pituitary. This activity will move to a wing of the clinical-center building where it will be closely associated with a clinical branch devoted to the study of diabetes and other endocrine diseases.

We shall have close collaboration between our Clinical Division and the basic science laboratories. The most important reason for the Clinical Center is to provide an earlier and better opportunity to carry to the patient the results of laboratory research which heretofore have had to wait—sometimes for many years—until interest could be aroused elsewhere. Likewise, the clinical investigator will have at hand the counsel of experts in the basic science laboratories. The environment thus created at Bethesda should stimulate all the institutes to increasingly important accomplishments.

Like the other constituent institutes of the National Institutes of Health, the Arthritis Institute also has an extramural activity. In this activity we have the guidance of a National Advisory Council composed of distinguished nongovernmental professional and public leaders in industry and education, and with our Council, are responsible for the wise disbursement of moneys appropriated by Congress for support of research projects, fellowships, and training activities in medical schools and other nongovernmental institutions.

I regret exceedingly that facilities up to date have been far from adequate to meet the demand that has been made upon us for such support. In addition to the funds presented in this budget, we have an anticipated requirement of something like $3 million in addition that we have in the form of requests already received. Of them, not less than 60 percent undoubtedly will receive the approval of the several study sections and of our own Council.

Before I close I would like to call attention to the fact that this Institute up to now has functioned within the general appropriation

of the National Health Institutes but now comes before you for separate consideration in accordance with the desire expressed last year by the Appropriations Committee of the House.

Thank you, gentlemen. I shall be glad to answer any questions you may have.

RECENT INTRAMURAL RESEARCH ACHIEVEMENTS

Mr. BUSBEY. Dr. Wilder, you mentioned that you would like to speak of a number of recent achievements in the laboratories. Would you like to comment on those at this point?

Dr. WILDER. I should indeed.

Crossing my desk these last 2 weeks has been the material for the preparation of our annual report. I do not have copies of this for distribution to you, but I want to show it to you just to indicate the breadth of it.

I spoke of our having four basic science laboratories. One is a physical biology laboratory in which there is a section on molecular biophysics, one on low energy radiation biology, another section on nuclear radiation biology, and one on physiological physics.

There is a laboratory of chemistry and a section on steroid chemistry. A Dr. Mosettig, who is with us is very actively engaged in the study of the transformance of one steroid to another. Many of these steroids, like testosterone and corticosterone can be changed one into the other. He is making an elaborate study of this which may have very great practical significance from the standpoint of sources of such drugs as cortisone. Also from the standpoint of developing new steroids with the cortisone effect that we desire, but free from the undesirable effects that have been commented on in connection with the use of cortisone.

We have a section of carbohydrate chemistry. I have spoken of being very proud of these laboratories. Two years ago, at the time that I arrived there, Dr. Claude Hudson retired. Dr. Hudson was known all over the world for his work on carbohydrate chemistry. The chemistry of sugars relates directly to biabetes; I have long been interested in sugar chemistry. It was my privilege as a young man to study with Professor Neff, at the University of Chicago. I was with him for a year. Naturally, I am interested in that field.

In the process of its utilization the body converts the sugar molecule into many other things. It is a sort of cycle that it goes through, and the identification of the different steps in the chemical breakdown of sugar in the body, is a matter of great importance.

Some of the men in the laboratory, Dr. Fletcher and others, are isolating and identifying the different sugar fractions, so to speak, that are involved in this cyclic metabolism, or breakdown of the sugar molecule.

Some of the intermediates that they have prepared are proving of great usefulness to those who are working in biology and other areas as materials for the investigation of metabolism.

We have a section on analgesics which is very important.

Dr. Nathan Eddy here is a member of national and international organizations for the control of narcotics, which is a very serious social problem. He works closely with Dr. Small, who heads the laboratory of chemistry.

Dr. Small and his associates have prepared a variety of substances, several of which can take the place of morphine or codeine. They are working continuously to try to find materials that will be free from the habit-forming effects of codeine and morphine with which we are all familiar. So far they have had to test these things.

When it comes to testing on the human being in the laboratory, that is supported mainly by the mental health group in Lexington, Ky. When we get our facilities in the clinical center, we expect to move Dr. Eddy in with his assistants, where, in close association with the department of anasthesia of the clinical center, they will have the opportunity for more rapid identification of the usefulness or otherwise of new analgesic drugs as they come along.

BIOCHEMESTRY AND NUTRITION

We have a lot of work going on in the laboratory of biochemistry and nutrition. These laboratories are really departments, in a way.

This one consists of four sections. Dr. Sebrell was most active as the head of this laboratory before he became head of the Experimental Biology and Medicine Institute, as it was called, before that became our Institute of Arthritis and Metabolic Diseases.

Dr. Sebrell's early work with riboflavin deficiency is an example of the accomplishments of that laboratory. His work with Goldberger revealed that pellagra was not exclusively the result of a deficiency of one vitamin, namely, nicotinic acid, but also involved deficiencies of other vitamins.

Dr. Sebrell was able to demonstrate that a deficiency of riboflavin produced characteristic lesions in human beings. Very great and important work is going on there.

I believe that Dr. Sebrell may have mentioned to you earlier today, that Dr. Schwartz, a visiting scientist, is an able man in liver diseases. He has produced a form of liver disease by nutritional means.

There is very active interest in nutritionally induced liver disease at present because of the widespread existence of such diseases in certain areas of the world, notably in South Africa, where it is a serious condition causing many deaths. It is sort of cirrhosis, but not like that which we know in this country.

This is being studied intensively and progress is being made in an understanding of the different forms of liver disease and what to do for each of them.

Certain specific factors have been isolated by Dr. Schwartz which are very effective in the treatment of this nutritional condition that he produces.

We have a section on endocrinology in which I am very much interested. It is headed by Dr. Anderson, who came to us from Dr. Herbert Evans, a name that is very widely known, who is responsible for the discovery of the activity in the pituitary gland attributable to the adrenal stimulating and the growth hormones. Anderson has been working on work that promises to be of extreme importance and perhaps will tie together some of the work of the mental-health people with endocrinology because she finds by producing lesions in certain parts of the brain, she can profoundly influence the functioning of different endocrine glands. She also profoundly influences the metabolism of carbohydrates and proteins.

Most recently they have done one thing that interests me tremendously. They have developed a technique for measuring the amount of insulin in a person's peripheral blood. The test animal is a mouse that they have hypothesectemized, that is, removed the pituitary gland from the brain, and made diabetic by injecting alloxan. Such a mouse is so susceptible to insulin that three one-millionths of a unit of insulin will cause a measurable drop in its blood sugar. We have been looking for such a technique for a long time because it has long been suspected that all diabetes may not be the same, and we have now learned that many of these endocrine glands raise blood sugar levels by the formation of sugar in the body and its utilization. It is very important for us to know how much insulin is in the blood in these different conditions, and this is the first time that we appear to have a satisfactory method of arriving at such assays.

We have another section in this laboratory of biochemistry, a section on fractionation and isolation, and within the last few years they have come up with very important material they have isolated from horse liver. It is the so-called citrovorum factor, which is closely related to, but not the same, as the synthetic folic acid now recognized as one of the important vitamins in the vitamin B complex. Its usefulness is not yet fully understood, but at least we seem to be nearer the vitamin that is used in the body than is folic acid.

There is a section of enzymic chemistry in the biochemistry laboratory. Heading that laboratory was Dr. Kornberg, whose studies involved principally an understanding of the chemistry of the enzymes in the body. The nucleus of the cell contains some very important enzymes which they have been studying intensively and satisfactorily. Kornberg's work was so important that he was given by the American Chemical Society the Paul Lewis award.

It happened that the following year another man in his laboratory, Dr. Honecker, received that award for research in this area. The award is made by the American Chemical Society in recognition of the most impressive and significant contribution of the year.

We feel very proud to have had this Paul Lewis award made twice in successive years to our institute. We regret, but at the same time we are very proud, that Dr. Kornberg has received a professorship in Washington University of St. Louis.

PATHOLOGY AND PHARMACOLOGY

Finally, we have a laboratory of pathology and pharmacology. This is something of a hodgepodge, I might say, but it contains some very important people and is doing some very important work. The head of it is Dr. Ralph Lillie, who is recognibed as one of the leading histochemists of the country. A histochemist works with a microscope. He tries to find dyes, stains, or other chemicals that will change the appearance of the constituents of cells. Dr. Lillie is recognized for his work in this field everywhere.

We have a section on pharmacology and toxicology of which Dr. Rosenthal is the head. Dr. Rosenthal has done some outstanding work. It was reported to you last year. It related to the immediate effect of the injection of enough salt solution into people that had had severe burns, or have been shocked by burns. His work, of course, was with rats, but is being continued now in studies on human beings.

It happens that a limb or other area that is burned attracts the salt and water from the other tissues of the body. So much salt and water go into the burned area that the rest of the body loses very vital and necessary constituents of its environment, of its internal environment. By giving enough salt water—and it can b given very easily by mouth—the immediate ill effects of severe burning may be overcome. That may prove to be of great importance to us should we face the catastrophe of another war, especially an atomic war. The subject is still under study. It has been endorsed by some authoritative bodies. It has been criticized by others. It helps the individual only for the time being. It must be followed by other things, such as antibiotics, blood plasma, and so forth. It may make a tremendous difference, and we think it is of great importance and are pressing it as hard as we can at the moment.

We have a section on pathological anatomy, which undertakes service not only for our own Institute but for many of the other institutes in connection with the examination of tissues of animals that have been studied. It also receives tissue for study from other places, particularly Public Health Service hospitals.

Part of this laboratory of pathology will move into the clinical center and be responsible for pathology there.

We have a section on metabolic and degenerative diseases, where some interesting things are going on, but I may be taking more of your time than you care to have me take.

We have another section on comparative pathology, which is concerned with the diseases of animals. It is of great help to us and other institutes of the National Institutes of Health because of the large use of animals that has to be made in biological studies. It is very important that an animal be not diseased before you start working on it. The care of the animals and the actual breeding of the animals, and so forth, will be under Dr. Thorp. That activity will be more or less under the direction of Dr. Sebrell's office.

I have talked about our intramural activities. I could tell you also about the work reported by our grantee if you wish to have me do so.

Mr. BUSBEY. It is quite evident, Doctor, that you, like most of the people at the Institute, are certainly wrapped up in your work and very enthusiastic about it. Your discussion has been very enlightening to the committee, I am sure.

Dr. WILDER. I have been enthusiastic, Mr. Busbey. I really think that we have a place there that we should all be proud of.

I am reminded of the attitude of the French medical and biological people toward the Pasteur Institute. I think that the French Government subsidizes in part the Pasteur Institute. I am sure you have heard about the Pasteur Institute and the fame it has acquired over the years. I feel toward this as I would if I were a Frenchman toward the Pasteur Institute.

CONTRIBUTIONS OF VOLUNTARY AGENCIES

Mr. BUSBEY. Doctor, how do the voluntary organizations in this field operate—the Arthritis and Rheumatism Foundation, the American Diabetes Association, and the others? What do their funds amount to per year?

Dr. WILDER. The American Rheumatism Association is an association of doctors, and a group of these doctors with some laymen interested in the problem of arthritis and of its significance in public health organized this Arthritis and Rheumatism Foundation. It has offices in New York City. Its total funds for the calendar year 1952 I believe amounted to—no; I cannot remember the figure——

Mr. BUSBEY. Just approximately.

Dr. WILDER. Their aim this year is $5,000,000. General Kenny, who used to be in the Air Force during the last World War, is in charge of their fund-raising program, and he has been around the United States seeing the various chapters and organizing drives for funds.

Mr. BUSBEY. How about the American Diabetes Association?

Dr. WILDER. That is simply an organization of doctors. They have never gone into fund raising at all. They have received relatively small funds for distribution. What they have had they have secured from some of the pharmaceutical firms. They have a small fellowship and research grants program.

Mr. BUSBEY. The funds of the Arthritis and Rheumatism Foundation are spent in what way?

Dr. WILDER. They are spent for educational purposes and to some extent for grants-in-aid. They maintain an office. They publish material for circulation. They obtain lecturers and send them around the country to lecture to the different local chapters, but more than that I cannot tell you. I do not have the details of their business in my mind, and I do not seem to have it here in these sheets.

1954 BUDGET ESTIMATE

Mr. BUSBEY. The request for the fiscal year 1954 is $8,450,000.

Dr. WILDER. That is correct, sir.

Mr. BUSBEY. And the fiscal year 1954 will be the first year that this has been carried as a separate appropriation.

Dr. WILDER. That is correct.

Mr. BUSBEY. As I figure it, this is an increase of $3,881,100 over the amount estimated to be spent for this purpose in 1953.

Dr. WILDER. That is correct.

Mr. BUSBEY. That is quite a jump, is it not?—an 80-percent increase?

Dr. WILDER. That is correct. But you must remember that a large part of that is for the medical-center activities.

Dr. SEBRELL. $2,000,000 of that is under the item "Construction of research facilities," which, as Mr. Stephens has indicated, has been eliminated. That is $2,000,000 of the $3,881,100.

Mr. BUSBEY. That would leave $1,881,100.

Dr. SEBRELL. The $1,269,000 is for research projects, that is, for grants.

BUDGET ESTIMATE FOR CLINICAL CENTER

Mr. BUSBEY. How much is directly attributable to the opening of the clinical center?

Dr. SEBRELL. $472,000 plus $54,600.

Dr. WILDER. That amounts to $526,600.

WORK ON OBESITY

Mr. BUSBEY. Now, in your general statement and also in your justifications under research grants and under direct research, you mention work regarding obesity and gout. I did not realize that these diseases or disorders were of such relative importance to the national health as to command the interest of the National Institutes. Is that of major importance in this research field?

Dr. WILDER. Well, perhaps gout is not, but obesity certainly is. It is estimated that 20 percent of the population are more than 10 percent overweight. It has also been impressed on everybody recently that overweight carries with it all sorts of jeopardy, leading to the various degenerative situations, such as hypertension and diabetes. It is true that overweight people die younger and also that the incidence of diabetes in the overweight is very much higher than it is in those who are of normal weight, or thinner. It is also true that hypertension and heart diseases are aggravated by overweight.

Now, obesity, I would say, is a very important public-health problem and one which we ought to know more about. It is assumed that the only reason that people weigh too much is because they eat too much, and perhaps that is true—it probably is true—but why they eat too much is a question that has not been answered, and we hope to have an answer to that from our respiratory chamber.

(Discussion off the record.)

REASONS FOR ESTABLISHMENT OF INSTITUTE

Mr. FOGARTY. I would like to assure you, Dr. Wilder, that I appreciated your remarks today and thought they were very interesting.

Your Institute is one of the newer institutes, is it not? It has only been established by law about 2 or 3 years. Was it 3 years ago that it was established?

Dr. WILDER. In 1950; yes. It is new in the sense that it is new under that name; it is old in the sense that it is built on top of a group of old laboratories that have existed almost since the beginning of the Public Health Service.

Mr. FOGARTY. It is also new in the sense and to the extent that Congress established it by law to enlarge the work that had been going on in this particular field.

Dr. WILDER. That is correct.

Mr. FOGARTY. Especially because of the discovery of cortisone and ACTH and their application in connection with arthritic diseases, particularly rheumatoid arthritis, in the hope of some relief and eventually the cure of arthritis.

Dr. WILDER. That is right.

Mr. FOGARTY. There were I do not know how many people in this country afflicted with arthritis and those other diseases you have discussed. That was one of the reasons Congress took some progressive action 3 years ago in setting up this Institute. That is why we wrote in our report last year that we wanted the Institute carried as a separate appropriation, like the Heart Institute and the Cancer Institute, so that people would know what we are doing in this field and why we are doing it, and that is why you show a fairly sizable increase. This is something new. It is something Congress just said

3 years ago to get started on. I do not know what the potential will be. I hope it will be a lot more than this in 2 or 3 years. That is my own feeling on it because I think the field is there to work in and, with the discovery of these new drugs, I hope some of these people will be given some relief.

Cortisone and ACTH and recently compound F have not been as effective as we had hoped in the beginning, have they?

Dr. WILDER. I do not know exactly how to answer that.

TREATMENT OF RHEUMATOID ARTHRITIS

Mr. FOGARTY. About 3 years ago I saw a movie developed by Mr. Hench, of Mayo Clinic, where people with rheumatoid arthritis who had been bedridden for years were given cortisone or ACTH and they were up and walking around.

CORTISONE

Dr. WILDER. Yes. That can be repeated any day you care to try. Unfortunately, the use of cortisone requires an expertness which few doctors possess. That is one of the reasons why we feel it is so important to have these traineeships in this particular area. We need to teach doctors how to use cortisone and ACTH. It is not free from danger when it is misused. As pointed out in the earliest publications from the Mayo Clinic, if it is used in doses that are inadequate, it is without effect; therefore, the results obtained when it is put on the market generally are not as enthusiastic as the public has been led to believe they would be from the results obtained by the experts.

Mr. FOGARTY. It is a continuing process, though, is it not?

Dr. WILDER. There was never any suggestion that cortisone would be a curative of arthritis; it was just a relief somewhat like the relief that insulin provides in diabetes.

Mr. FOGARTY. It is not as effective as insulin in the case of diabetes?

Dr. WILDER. It can be in an early case of a patient with rheumatoid arthritis; that is, before the patient has developed any deformities, before he is terribly crippled because of the contraction of his muscles and the swelling of his joints. It then can completely relieve the condition so that the individual is comfortable and free from pain. Of course, if you take a patient who has had the disease for a long time has has suffered from damage to his joints, it will not change that. It provokes a subsidence of the acute phases of disease. However, after the drug is discontinued the symptoms return.

I feel the public obtained an erroneous impression about cortisone at the beginning, but I do not think the Mayo people were responsible for that, because they were very careful in the presentation of their data to avoid giving that unjustified interpretation.

Mr. FOGARTY. How many people are estimated to be afflicted with some form of arthritis or rheumatism?

Dr. WILDER. The National Health Survey of 1938 came up with a figure of about 6.5 million people. If you extrapolate that to the present population, it would represent about 8 million people. A study was made in the Surgeon General's Office by Dr. Woolsey, who reported in Public Health Reports this year, figures very close to those arrived at by the National Health Survey. I think I mentioned in my

opening statement the number that are disabled to the extent they cannot work.

COMPOUND F

Mr. FOGARTY. What are you doing with compound F? Was it not after cortisone and ACTH that compound E came along?

Dr. WILDER. No. That was cortisone—compound E.

Mr. FOGARTY. That was cortisone?

Dr. WILDER. Compound F is known as hydrocortisone. It is more likely that it is the actual secretion of the adrenal cortex rather than compound E. Compound F does affect rheumatic diseases and other diseases in which cortisone is effective with about the same results as compound E. However, it can be given with advantage (and one of our grantees in Pennsylvania was the first to bring this out), by direct injection into the inflamed joint. Compound F in small doses can be injected directly into the joint with remarkably beneficial effect.

Mr. FOGARTY. So that is an improvement over cortisone?

Dr. WILDER. For that particular purpose it is.

TREATMENT OF OTHER METABOLIC DISEASES

Mr. FOGARTY. What about these forms of arthritis other than rheumatoid arthritis? Are you making any progress in that field?

Dr. WILDER. Progress is being made. We are not actually engaged in the study of anything except gout. You mentioned gout. Gout is not a common disease, but it is a very interesting disease to study, because it represents a changed metabolism. In recent days new drugs have been discovered for gout. Butazolidin is one of these; another is benemid.

Mr. FOGARTY. I think cortisone in some recent cases had the same effect.

Dr. WILDER. Yes; it does. It relieves the pain of gout.

Mr. FOGARTY. Gout is more prevalent in heavy people; is it not?

Dr. WILDER. That is true; yes.

Mr. FOGARTY. It is very painful; is it not?

Dr. WILDER. It is extremely painful—an acute attack of gout.

Mr. FOGARTY. What about bursitis; is that a form of arthritis?

Dr. WILDER. It is related to arthritis. It is one of those manifestations of inflammation of the synovial lined sections in the body. Bursae they are called. The joint has a similar lining, and the same kind of disease may effect a bursa.

Mr. FOGARTY. You can help that with surgery; can you not?

Dr. WILDER. Yes; sometimes, by removing the bursa. Usually, however, they respond pretty well to other methods of treatment—X-ray treatment, for instance, is oftentimes helpful, and cortisone will relieve the pain of bursitis.

Mr. FOGARTY. Has it not been found that cortisone or ACTH has been very beneficial in the treatment of third-degree burns?

Dr. WILDER. It was so claimed, but I believe that has not stood up. I do not believe it has.

Mr. FOGARTY. I think someone told us a couple of years ago about some accident down in Texas where it was used.

Dr. WILDER. That is correct. It received a lot of newspaper publicity, but it has not stood up.

Dr. SEBRELL. I have been concerned about a study down here at Richmond, at the Medical College of Virginia, by a prominent surgeon with the assistance of the National Research Council, and his better controlled experiments have not confirmed the early impressions of what was hoped to be a very good use for these compounds. They have an effect on the stimulation of the appetite.

Mr. FOGARTY. Did this fellow referred to die?

Dr. SEBRELL. No. I cannot remember his name now.

Mr. FOGARTY. As I remember, there was a case written up in the papers or described to us. Anyway, it was said that it was impossible for anyone with that degree of burn to live, but he was living some months after the accident had happened.

Dr. WILDER. That is right. Apparently a very remarkable result was obtained in that patient. But there may have been other factors that we do not know about or did not hear about that contributed to it.

Mr. FOGARTY. Some people cannot take cortisone; is not that so?

Dr. WILDER. That is right. At least, you would not want to give cortisone to a person with tuberculosis. It aggravates tuberculosis. There has been some question as to whether you ought to give cortisone to a person with diabetes, because it aggravates diabetes. Personally, however, I think you can give cortisone to a person with diabetes if you treat the diabetes with more insulin at the same time.

Mr. FOGARTY. Insulin for diabetes, which was discovered, as you said, sometime in the early '20's, allows a person with diabetes to live a long life; whereas before the discovery of insulin, he had no chance. Is not that correct?

Dr. WILDER. Many cases of diabetes are mild enough so they can live without insulin. Severe cases of diabetes used to die, now they live.

Mr. FOGARTY. He lives because of insulin?

Dr. WILDER. That is right.

Mr. FOGARTY. I heard somebody say the other day he did not believe in these drugs for arthritis and, even though he might put on some weight, he has been eating a lot of butter recently and he thinks that by eating a lot of butter every day that will give him the necessary factors in his system that are lost when a person has arthritis. Did you ever hear of anything like that?

KETOGENIC DIET FOR ARTHRITIS

Dr. WILDER. I have not. I personally was responsible for the treatment of epilepsy a number of years ago by what was called a ketogenic diet. It was known that starvation was helpful in epilepsy, and I came away from a medical meeting in which a report had been made on the benefit derived from starvation in epilepsy, and thought to myself "Maybe you could produce the chemical conditions of starvation simply by feeding a diet that would be very high in fat and very low in carbohydrates and only provide enough protein to cover protein needs." It came to be called a ketogenic diet and has been used ever since in the treatment of epilepsy with some success, especially in children. It would be the kind of diet you are talking about, with lots of butter.

Before we had insulin, we also were interested for some years in treating diabetics with diets that were relatively high in fat and low in protein and carbohydrate. It was not a very successful treatment, although it did permit keeping people alive longer than they otherwise would live. But I do not know of any relationship of this butter treatment to arthritis.

Mr. FOGARTY. Cortisone is still very expensive; is it not, even though it has been coming down in price every year?

Dr. WILDER. I think the estimate now is that the cost of the cortisone a person needs to take is not more than $1 a day.

Mr. FOGARTY. Every day?

Dr. WILDER. Every day that you are using the cortisone. That is not so awfully expensive. And, of course, you can expect it to come to a lower level than that, particularly if some of the research now under way—I mentioned some of it in our own institute—should lead to easier ways or cheaper ways of making it.

RESEARCH BY PRIVATE CHEMICAL COMPANIES

Mr. FOGARTY. Of course, these chemical companies are spending money on research for the same purpose—to get the price down.

Dr. WILDER. They are looking to the same ends.

Mr. FOGARTY. Who is the principal supplier—Merck?

Dr. WILDER. Merck & Co., I think, is the principal supplier.

Mr. FOGARTY. Is Armour doing some work in that field?

Dr. WILDER. Armour is mainly interested in ACTH. That is the active hormone from the pituitary which stimulates the production of steroids like cortisone by the adrenal cortex.

Dr. SEBRELL. Along that line, the Upjohn Co. recently reported a new method of making cortisone by an entirely new process involving bacteria growth or mold growth. That applied to a particular compound, and they are now on the market with their new method of making cortisone which may bring the price down some.

PROBLEMS OF ADMINISTERING CORTISONE

Mr. FOGARTY. In order for the physician to administer ACTH or cortisone, he has to know what he is doing; he has to know what the reaction is?

Dr. WILDER. That is absolutely correct; yes.

Mr. FOGARTY. More should be known about it than is known at the present time by general practitioners throughout the country? Is that so?

Dr. WILDER. You are absolutely right. That is one of the reasons I am so anxious for you to allow us some money for traineeships, so that we can get more doctors to use these materials the way they ought to be used.

Mr. FOGARTY. There were some violent reactions when this was first used; were there not? And have not you overcome many of those reactions?

Dr. WILDER. We have a grantee, Dr. Robinson, of the University of Michigan, at Ann Arbor, who has studied that question very carefully. Excess cortisone will provoke the growth of hair on a woman's face, cause fattening of the face, excretion of sugar in the urine, and other

disturbing things. They can be prevented if the dose is properly adjusted. You frequently have to give less than you would like to give to completely relieve the pain that the patient has in order to avoid those things—which, of course, you should avoid. You also should stop your medication when those symptoms develop, with the idea of starting it again later. They are reversible; in other words, you can avoid them by small enough doses, or you can correct them by simply stopping using the drug and then use the drug later.

Mr. FOGARTY. In other words, you have to be an expert in the field if you are going to properly administer this drug?

Dr. WILDER. Exactly. Medicine has become a profession in which much more needs to be taught than was necessary when I went through medical school. It is a complicated business, using these new miracle drugs. Aside from surgery entirely, which, for a generation, attracted most notice—had the limelight, so to speak—the practice of medicine now has become a very complicated business. When I started to study medicine, you could name on the fingers of your two hands the drugs that were really of any great value in the treatment of any disease. Since then there have been developed all of these antisera for the different infections, all of the antibiotics, sulfa drugs, and now these endocrine drugs, and to use them wisely and intelligently requires a medical education that is far more complicated, far more elaborate than what I received when I went to medical school.

Mr. FOGARTY. You have been at it for quite awhile; have you not?

Dr. WILDER. I graduated from Rush Medical College in 1912. So, you see, it is 41 years that I have been in medicine.

Mr. BUSBEY. If there is nothing further, thank you very much, Doctor.

Dr. WILDER. Thank you, Mr. Busbey.

WEDNESDAY, APRIL 1, 1953.

MICROBIOLOGY ACTIVITIES

WITNESS

DR. VICTOR HAAS, DIRECTOR, NATIONAL MICROBIOLOGICAL INSTITUTE

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate			$7,000,000
Reimbursements from other accounts			172,500
Obligations incurred			7,172,500
Comparative transfer from "Operating expenses, National Institutes of Health, Public Health Service"	$5,502,127	$5,650,200	
Total obligations	5,502,127	5,650,200	7,172,500

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
Direct Obligations			
1. Grants for research and training:			
(a) Research projects	$1,947,264	$1,950,000	$2,947,000
(b) Research fellowships	118,457	150,000	117,000
2. Direct operations:			
(a) Research	2,888,166	3,221,350	3,718,000
(b) Other direct operations:			
(1) Review and approval of research and training grants	14,478	14,550	15,000
(2) Administration	137,191	143,300	203,000
Total direct obligations	5,105,556	5,479,200	7,000,000
Obligations Payable Out of Reimbursements From Other Accounts			
2. Direct operations:			
(a) Research	396,571	171,000	172,500
Total obligations	5,502,127	5,650,200	7,172,500

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Summary of Personal Services			
Total number of permanent positions	463	462	490
Full-time equivalent of all other positions	56	31	31
Average number of all employees	472	442	461
Average salaries and grades:			
General schedule grades:			
Average salary	$4,056	$4,163	$4,212
Average grade	GS–5.2	GS–5.3	GS–5.6
Crafts, protective, and custodial grades:			
Average salary	$3,139	$3,189	$3,189
Average grade	CPC–4.3	CPC–4.3	CPC–4.3
Ungraded positions: Average salary	$4,284	$4,615	$4,615
Personal service obligations:			
Permanent positions	1,887,115	1,944,436	2,055,137
Part-time and temporary positions	219,351	133,166	124,666
Regular pay in excess of 52-week base	5,964	6,011	6,560
Payment above basic rates	26,761	10,500	10,500
Total personal service obligagions	2,139,191	2,094,113	2,196,863
Direct Obligations			
01 Personal services	1,951,976	1,998,447	2,102,697
02 Travel	57,687	56,800	59,800
03 Transportation of things	10,924	11,250	14,750
04 Communication services	13,442	14,100	15,100
05 Rents and utility services	11,393	11,600	11,700
06 Printing and reproduction	12,725	13,150	15,750
7 Other contractual services	14,739	21,900	17,300
Reimbursements to "Operating expenses, National Institutes of Health, Public Health Service."	630,346	915,550	1,337,000
08 Supplies and materials	252,309	254,950	280,000
09 Equipment	82,125	80,050	80,050
11 Grants, subsidies, and contributions	2,065,721	2,100,000	3,064,000
13 Refunds, awards, and indemnities	65		
15 Taxes and assessments	4,178	4,245	4,695
Subtotal	5,107,630	5,482,042	7,002,842
Deduct charges for quarters and subsistence	2,074	2,842	2,842
Total direct obligations	5,105,556	5,479,200	7,000,000
Obligations Payable Out of Reimbursements From Other Accounts			
01 Personal services	187,215	95,666	94,166
02 Travel	10,314	10,140	10,240
03 Transportation of things	3,463	600	600
04 Communication services	1,908	800	800
05 Rents and utility services	2,505		
06 Printing and reproduction	179		
07 Other contractual services	44,597	23,544	23,544
08 Supplies and materials	114,925	30,100	31,500
09 Equipment	30,744	10,150	11,650
15 Taxes and assessments	721		
Total obligations payable out of reimbursements from other accounts	396,571	171,000	172,500
Total obligations	5,502,127	5,650,200	7,172,500

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Obligations incurred during the year			$7,172,500
Deduct:			
Reimbursements received			172,500
Unliquidated obligations, end of year			2,240,000
Total expenditures (out of current authorizations)			4,760,000

Mr. BUSBEY. We have before the committee for consideration this morning the appropriation request for fiscal year 1954 for the microbiology activities of the Public Health Service.

Dr. Haas, I believe you have a statement you would like to make to the committee at this time.

Dr. HAAS. I have, Mr. Chairman.

GENERAL STATEMENT

Mr. Chairman and members of the committee, perhaps no field of medical research has registered greater gains in this century than microbiology. Many epidemic diseases—one need only mention typhoid, smallpox, and diphtheria—have virtually disappeared in this country. So rare are these once feared diseases that Americans tend to equate them with the almost extinct whooping crane and the buffalo as symbols of a vanished era.

Yet, despite striking progress in recent decades, there is little evidence to justify a complacent view of communicable diseases. Many of them, such as influenza, the common cold, and poliomyelitis, are still very much with us. In terms of aggregate illness and economic loss, they represent a heavy burden, even to a strong and productive nation. In terms of research, they remain complex, baffling, elusive problems.

In a sense, the field of microbiology might be compared to a modern military campaign in which attacking forces move swiftly against central strongholds of the enemy and bypass isolated areas of resistance. With the major objectives now realized—that is to say, the principal epidemic diseases once important in terms of death rate—there remains the infinitely difficult job of attacking by slow attrition those diseases which still elude the best efforts of science.

More and more, this method of attack is centered in fundamental research which frequently has no direct bearing on a specific disease. The objective is to uncover new knowledge of basic life processes—knowledge which may one day provide a clue to how a given disease organism grows, thrives, and multiplies. Scientists are presently studying the metabolism, the enzyme activity, and the synthesis of microorganisms ranging from viruses to typanosomes (which cause African sleeping sickness). They are plotting the mode of action of antibiotics and investigating resistance which organisms can develop against such compounds. These studies, when they attain their ultimate goal, will make it possible to develop a rational approach to the prevention and treatment of disease.

At the National Microbiological Institute, this work has undergone shifts in emphasis and in approach to meet new problems, new knowl-

edge, and new public-health needs. Virus and rickettsial diseases now demand the same heavy emphasis that bacterial diseases required in past years. Bacterial diseases, on the other hand, have been required to take a new approach to meet problems developing under conditions of population stress, sanitation failures, and the like. At the same time, gaps in neglected and lagging areas of study must be filled if we are to maintain and strengthen existing public-health gains.

RESPONSIBILITIES AND ORGANIZATION OF INSTITUTE

Briefly stated, the National Microbiological Institute is responsible for conducting, coordinating, and stimulating fundamental research in the broad field of microbiology, and for the operation of a national program of biologics control. To carry out its responsibilities, the Institute is organized into four main research laboratories, a newly established clinical investigation unit, and an Extramural Programs Branch for the support of research in other institutions through grants-in-aid.

ACTIVITIES AND ACCOMPLISHMENTS

The nature of these activities and the accomplishments they produced in the past year are reflected in the studies summarized briefly in the following pages. In many cases the results represent collaborative effort, not only among scientists of this Institute but those of private institutions and other governmental agencies as well.

MALARIAL DRUGS

One of the most notable advances made by scientists of the National Microbiological Institute in the past year involved the search for new drugs to combat malaria. This work was broadened at the request of the Army in the spring of 1951, at which time the number of cases of relapsing malaria among troops returning from Korea was climbing swiftly, reaching rates as high as 600 a week by midyear. A clinical testing program was established to evaluate two promising synthetic drugs, Primaquine and Daraprim. These tests, utilizing prisoner volunteers at the Atlanta Penitentiary, were carried out with the cooperation of the Federal Bureau of Prisons and with the financial aid of the Army.

Primaquine, the first drug tested by National Microbiological Institute scientists, proved to be a simple, inexpensive, almost "sure cure" for relapsing malaria. The drug was adopted by the Army and is being administered to men returning to this country from Korean duty.

The results obtained with the second drug, Daraprim, indicated a compound more promising in some respects than Primaquine, in that it does a complete job of suppressing as well as curing malaria.

Daraprim is highly active in extremely small doses, is tasteless, and can safely be administered for long periods. Prisoner volunteers given 25-milligram doses of Daraprim each week for periods as short as 8 weeks failed to come down with malaria many months after being infected, indicating that Daraprim is apparently curative at that dosage level. The drug is cheap, both because it is inexpensive to manufacture and because it is so powerful that a little goes a long

way. These are important advantages for public health programs in Asia, Africa, South America, and other regions where malaria has been a major health problem for centuries. Worldwide, the disease still strikes an estimated 300 million persons a year and kills 3 million.

The significance of these drug advances can scarcely be overstressed. For malaria has long been an economic burden even for the United States, where the disease has virtually disappeared in recent years. According to one distinguished authority, Dr. Paul Russell of the Rockefeller Foundation, "Imports from malarious countries carry a 'malaria tax,' probably of not less than 5 percent, due to the fact that malaria among laborers always increases the cost of what these workers are trying to manufacture or produce. This 'assessment' may total over $175 million yearly for the United States alone." That is the estimate of Dr. Russell.

ANTIBIOTIC DRUGS

In other studies, scientists of the National Microbiological Institute have made encouraging progress in uncovering new knowledge of bacterial resistance to the antibiotic drugs, a problem of increasing importance today in the practice of medicine. Experiments in the past year indicate that the development of resistance is not the only factor responsible for failure in treatment with the antibiotics. The physiologic state of the bacteria has been shown to have a marked influence on the therapeutic effect of penicillin. If bacteria are in a state in which they are not actively growing and multiplying, the organisms, paradoxically, are then relatively insensitive to the bactericidal action of the drug.

It has been further shown that the pH (degree of acidity or alkalinity) of the culture medium—and presumably the pH of body fluids—strikingly modifies the antibacterial action of penicillin, streptomycin, terramycin, chloramphenicol, and bacitracin—all antibiotics. These findings are significant in understanding the mode of action of the antibiotics. They are also of practical importance in relation to the direct application of these drugs in the treatment of infections of the urinary tract.

UPPER RESPIRATORY ILLNESSES

Upper respiratory illnesses, popularly described as "virus infections" or "influenza-like diseases," represent the most frequent ailments of man. In terms of lowered productivity and absence from work, their cost to the Nation is heavy. Much has been learned about some of these illnesses by scientists of the National Microbiological Institute in the last 2 or 3 years through combined epidemiological-laboratory studies. These investigations have indicated that a new family of organisms, the Coxsackie viruses, produce infections in man more often than almost any other group of viruses, except perhaps those responsible for influenza.

One such study was made in northeastern Texas, where an extensive outbreak of epidemic pleurodynia occurred. Known also as Devil's grippe, the disease was shown to be caused by a certain group B type of Coxsackie virus, although many strains of group A viruses were also recovered from persons in the community under study.

What role the A viruses played in the production of illness during the pleurodynia outbreak remains to be determined.

In other studies of the group A Coxsackie viruses, carried on in collaboration with the Army Medical Center, concentration and purification of these extremely small viruses were achieved to an unprecedented extent, and considerable information was acquired concerning these organisms.

INFANTILE PARALYSIS

During the past year there have been many advances in the search for new knowledge of poliomyelitis (infantile paralysis). National Microbiological Institute scientists have been able to grow strains of polio virus in chick embryos and by tissue culture methods. The tissue culture work is important as an approach for testing gamma globulin, the blood fraction which contains the antibodies which protect against disease. It also offers a long-range approach to the development of a true vaccine for poliomyelitis.

An epidemiological study of poliomyelitis also produced significant findings in the past year. This study indicated that the spread of poliomyelitis during the summer months is related to increasing humidity and not temperature alone. The new evidence suggests that the condition of the mucous membranes of the nose and throat may have an important bearing on the spread of poliomyelitis. Increased nasal secretions during the winter months appear to have a protective effect against the disease.

HEPATITIS

Of vital interest to the Nation's blood-collection program are the preliminary findings made in the past year by scientists of the National Microbiological Institute engaged in extensive studies of hepatitis. One phase of this project, necessitated by the absence of any laboratory animal susceptible to the virus of hepatitis, concerns clinical studies to evaluate irradiation as a measure for sterilizing plasma and whole blood to remove the danger arising from injection of human blood containing the organism. These studies are being carried out with the financial support of the Army and in cooperation with the Federal Bureau of Prisons.

Results to date indicate that ultraviolet irradiation of plasma cannot be relied on to inactivate the agent of serum hepatitis, but that some chemical agents seem to inactivate this virus under experimental conditions. Other findings point to the fact that some individuals are carriers of the virus even though apparently well; that the virus is much more resistant to heat than was previously thought; and that diet may be an important factor in treatment of hepatitis.

TULAREMIA VACCINES

Scientists of the National Microbiological Institute also report that investigations of tularemia vaccines have revealed important differences in the effects produced by these biologic products. Approximately 75 percent of individuals vaccinated with phenol-killed vaccines developed toxic reactions. This compares with about 10 percent among those vaccinated with ether-extracted vaccines. In addition,

analysis of blood tests indicated that the ether-extracted vaccines produced a higher rise of antibodies, persisting over a longer period, than did the phenol-killed vaccines. In studies with experimental animals, it was shown that ether-extracted vaccines are fully as potent as other types of vaccine, with the added advantage of very little toxicity.

SCHISTOSOMIASIS

The use of cheap, potent chemicals for killing snails offers the most efficient means of controlling schistosomiasis, a chronic debilitating disease which numbers its victims throughout the world in the tens of millions. In Egypt alone, 90 percent of the population in some areas is afflicted with schistosomiasis, and that nation's productive potential is estimated to be lowered one-third. During the past year, more than 500 chemicals were tested for their ability to kill snails under controlled laboratory conditions. On the more promising compounds, studies were made on the safety and ease of handling, solubility, dispersal and residual effect, influence on organic matter, and effect on other aquatic life. Methods for quantitative chemical determination of two compounds have been developed, and these procedures have been adapted for use by field personnel.

LABORATORY OF BIOLOGICS CONTROL

The Laboratory of Biologics Control is responsible for the administration of the biologics law, which is directed at assuring the public of safe, potent, and sterile biological products such as serums, toxins, antitoxins, human blood, and blood derivatives. This is achieved through licensing manufacturing establishments as well as the specific products involved. Licensing is contingent upon the manufacturer's meeting and maintaining certain standards and is insured by periodic inspection of establishments and continuous check of manufactured biological products.

The Laboratory of Biologics Control also conducts original research. One study now under way and receiving increased emphasis concerns the development of practical, satisfactory methods for standardizing immune serum globulins for poliomyelitis antibodies and for evaluating poliomyelitis vaccines. Preliminary standards have been set and tests are being made for uniformity of potency for the three types of polio virus.

The same laboratory is conducting studies on influenza viruses isolated in epidemics and outbreaks in various parts of the world in an effect to determine the effectiveness of present vaccines and to improve them. Significantly, in the winter of 1951–52, only type B influenza virus strains were isolated, and they were similar to those isolated in the winter of 1950–51. The similarity was great enough to preclude any necessity of substituting a new B strain in the present vaccines. However, in the past winter's outbreaks, the type of virus isolated was A-prime. This illustrates some of the difficulties involved in producing a vaccine which will afford protection against a virus which changes from time to time.

COOPERATION IN INFLUENZA STUDY PROGRAM

As part of the worldwide influenza-study program sponsored by the World Health Organization, the National Microbiological Institute serves as the influenza information center for the network of independent research laboratories cooperating in the study program in this country. The objective of the program is to study closely all outbreaks of influenza and disseminate rapidly information on these outbreaks through the worldwide network of listening posts set up by the World Health Organization.

SECTIONAL RESEARCH PROGRAM

To expand the Nation's research potential in dealing with outbreaks of infectious disease of whatever origin, the National Microbiological Institute was given responsibility for the scientific direction and administration of the sectional research program, which is part of the Institute's grants-in-aid program to support studies being conducted in universities and other research institutions. During the past year, 11 sectional groups embracing 98 participating laboratories were organized throughout the country. Important diagnostic materials have been made available and a total of 44 research grants amounting to $202,899 awarded to these laboratories.

GRANTS FOR RESEARCH AND TRAINING

For its entire grants program, the Microbiological Institute is currently supporting 244 grants, totaling $2,177,813. These studies have yielded a number of significant findings, the broad implications of which are of vital interest to all scientists engaged in microbiological research. At the Massachusetts Institute of Technology, for example, Dr. Murray P. Horwood, with the aid of a grant, has been investigating the germicidal effects of ultrasonic vibrations upon bacteria. His experiments have shown that the age of the bacterial culture affects the rate of germicidal action. The younger cultures (24 hours) were more resistant to ultransonic energy than the older ones (168 to 192 hours).

These studies also demonstrate that the environmental temperatures of the bacterial suspension alter the killing rate—the higher the temperature, the more rapid is the rate of germicidal action. At 98° F., complete sterility is obtained after ultrasonic treatment for 60 minutes. When the environmental temperature is increased to 140° F., it appears possible to obtain almost instantaneous sterilization of bacterial suspensions. The significance of these findings applies not only to the treatment of water and sewage but also to other media in which sterilization is an important factor.

At the University of Chicago the investigations of Drs. William Lester, Jr., and Clayton G. Loosli, supported by a grant from the National Microbiological Institute, have revealed the profound influence of relative humidity on the survival of infectious agents deposited on surfaces.

Survival was maximum at low relative humidity—16 percent—and decreased progressively as the humidity was raised. Streptococci survived with no apparent decrease in numbers for more than 18 months

at low humidities, and influenza virus retained demonstrable infectivity for more than 6 months under the same conditions.

These findings have great potential importance in relation to environmental sanitation and to the transmission of airborne infections. Pathogenic agents dispersed into the environment are subjected to a wide variety of physical and chemical processes which are significant in determining the survival and infectivity of organisms.

The work I have just discussed is a clear indication that substantial progress is being made against the infectious and parasitic diseases that still afflict men. There is much, however, that remains to be learned before we can truly speak of the conquest of the communicable diseases.

I appreciate your interest in our work. In common with the arthritis and neurology research programs at the National Institutes of Health, our research in microbiology is this year for the first time being carried as a separate appropriation item for fiscal year 1954. Thus this is my first formal appearance before a congressional Appropriations Committee. I have enjoyed being here, and I will be happy to answer any questions you might have about our research activities.

VIRUS DISEASES

Mr. BUSBEY. Doctor, you have been discussing various types of viruses during your statement. I am wondering if the term "virus infection" is not used in many instances where the doctor really does not know what the trouble is and so makes this diagnosis hoping that the patient will accept it.

Dr. HAAS. It perhaps is an analysis that they hope the patient will accept. Or I should say "we," because all of us doctors are alike in that we hope the patient will accept it and hope our colleagues will accept it. But actually there are a number of very specific diseases which are readily identifiable, such as poliomyelitis and influenza, in which the virus has been isolated and worked with for many years. But there is a great group of diseases, many of them apparently of a respiratory nature, believed to be of virus causation in which the viruses have not been tracked down; they have not been gotten at and isolated. I might say I have had four such attacks this winter myself, and I do not know what caused them.

DEFINITION OF VIRUS

Mr. BUSBEY. I am sure the other members of the committee understand this term "virus," but I am frank to admit I do not. What is a virus?

Dr. HAAS. A virus is a very small living agent, perhaps the smallest and most primitive in the sense of its being unable to exist by itself. It cannot live free. It must live within the cell of a so-called host. Apparently it does not possess enough materials which we call enzyme materials, which enable it to take the material out of its environment and change it to nutritive material for its own use. It does not possess enough of those enzymes to enable it to live outside the host, and it is completely parasitic and depends upon the host for support and material with which to create new virus.

Dr. VAN SLYKE. I was hoping Dr. Haas would say to you that the virus is so small it cannot be seen by the microscope. It is never seen as such except under the electron microscope.

Is not that right?

Dr. HAAS. That is right.

Mr. BUSBEY. You identify it pretty much by the effect it has on the respiratory system in connection with certain ailments, then?

Dr. HAAS. In some instances the respiratory system and in other instances the nervous system, depending upon what virus we are dealing with.

ESTABLISHMENT OF INSTITUTE

Mr. BUSBEY. You stated that this is being considered for the first time as a separate appropriation item for fiscal year 1954. Was that at the request of the committee?

Dr. HAAS. Yes, sir; that was.

Mr. HARLOW. Not directly. The request of the committee was directed to two new institutes established by Congress, but that left this one still hanging in the air so there seemed to be nothing else to do but to set it up as a separate item.

Mr. STEPHENS. There is another point to that. When it came up without being specifically mentioned by the committee, we questioned the logic of slighting another one. By just a tiny bit of investigation, we found it cuts across all of them, and you could not tie it with any other exactly, since it works with all of the others, and the only logical way to make it stand up was to set it up as a separate activity.

COMPREHENSIVE CHARACTER OF WORK

Mr. BUSBEY. I was wondering about that, because I could not help noticing that you are dealing with many of the same diseases that are being dealt with under the appropriation entitled "Control of communicable diseases." And from your statement I take it there is no clear division in this general field of work between the two appropriations.

Mr. STEPHENS. Or, say, between 5 or 6 appropriations. This Institute might be used, as I understand it, on virus and micro-organisms that might affect all of the institutes; so it was not logical to put it in cancer or neurologic and blindness or denal. It is something that serves as an independent entity.

RELATIONSHIP OF WORK TO "CONTROL OF COMMUNICABLE DISEASES"

Mr. BUSBEY. Then, Dr. Haas, there would not be any particular advantage in combining your appropriation with the control of communicable diseases?

Dr. HAAS. No, sir. We have felt there would not be. Their orientation is toward the actual control of diseases, working with the State and local health departments to that end; our orientation is toward the acquisition of new knowledge which, of course, ultimately will contribute to the fundamental goal of the control of diseases, but our immediate objective differs.

Mr. BUSBEY. In your opinion, what would be the disadvantage of combining this with the control of communicable diseases?

Dr. HAAS. We are located, of course, at the National Institutes of Health, of which we are a part. Our scientists, perhaps, could not do a major part of their work were they not in daily contact or were not a part of the total scientific community of the NIH. Many of our research projects in microbiology are carried on in collaboration with projects in other institutes on the same campus. Our scientists have frequent—sometimes daily—contact with one another across institute lines; they share laboratory equipment; and they share knowledge. They are all a part of research and, of course, that makes for a continuity of effort.

RELATIONSHIP TO CONTROL OF TUBERCULOSIS

Mr. BUSBEY. Are you doing any work on tuberculosis?

Dr. HAAS. Yes, sir; we are.

Mr. BUSBEY. How is your work related to the appropriation "Control of tuberculosis"?

Dr. HAAS. I think there is a comparable situation there with the one in the control of communicable diseases. The other appropriation is concerned with determining the incidence of tuberculosis and preventing and controlling it; we are concerned with fundamental research which will give us more knowledge about the organism which causes the disease, the things that can be done to try to change the nature of the organism, the way in which the infected animal reacts to the infection. Ultimately the things we discover would be put to use by the people in direct contact with the control project, but our orientation is toward the acquisition of more knowledge.

Dr. SHANNON. If I may comment on this general question, Dr. Haas is primarily concerned with the acquisition of new knowledge; the control programs are primarily concerned with the application of preexisting knowledge. It is just about as clean a cut as that. And that would go on down the line in all control programs as opposed to all of the research programs in the National Institutes of Health.

Mr. BUSBEY. Are you doing any work in the field of venereal disease?

Dr. HAAS. No, sir.

IMPORTANCE OF SCHISTOSOMIASIS WORK IN EGYPT AND ELSEWHERE

Mr. BUSBEY. You referred to the situation in Egypt and stated—

During the past year, more than 500 chemicals were tested for their ability to kill snails under controlled laboratory conditions.

Is that important to the health of the citizens and taxpayers of the United States who are footing the bill for this work?

Dr. HAAS. Yes, sir, Mr. Busbey; it is. The snail, of course, is the animal in which the little worm which causes this disease resides when it is going through its life cycle. Were these snails brought under control, there would be no disease called schistosomiasis. It is true we do not have that disease in this country except in those persons who have acquired it abroad, but we are committed to aid in a great many countries throughout the world where this disease is present. Egypt is cited only as an example. It is prevalent in some South American countries, in many regions of Africa and Asia, and many

countries where we have made direct contributions to welfare. We have it in one area where the United States is directly concerned—Puerto Rico—and in another area where the United States has been concerned for many years—the Philippine Islands.

The logical control of this disease is the attack on the snail. It happens that in the United States we have two species of snails which have been shown to be capable of transmitting this little worm under laboratory conditions that have never done so in nature. The disease has never been successfully introduced into this country, but it is conceivable under conditions which might arise in times of national stress that it could be established, just as it was in South America.

Mr. BUSBEY. Do people get this disease from eating snails?

Dr. HAAS. No, sir. The little worm that causes schistosomiasis goes through a developmental period in the snail and then is discharged from the snail and swims about in the water, is for a short time a free swimming little organism, and when people go into that water either for wading, bathing, or washing clothes, this organism penetrates the skin, bores into the skin, and then is ready to go on its way to produce this disease. It can also be obtained by drinking that water.

The snails which transmit this disease are not what are considered edible snails. I do not know that I would consider any snails as edible snails, but these snails by and large are very small snails and are not used for that purpose. But with people who have to go into those streams—a good example is our own soldiers during war—we had a lot of this disease acquired on Leyte, where our troops had to wade the streams and, even with their clothes on—the little worms penetrate and set up the infection.

EXPENDITURES FOR BIOLOGICS CONTROL

Mr. BUSBEY. Now you mentioned that the Laboratory of Biologics Control is responsible for the administration of the Biologics Law. How much of the appropriation is spent on this activity?

Dr. HAAS. Our present allocation for fiscal 1953 is $228,533 plus $100,000 reimbursable.

OTHER WORK ON PRIMARILY FOREIGN TROPICAL DISEASES

Mr. BUSBEY. Going back to the tropical diseases, what other diseases are you working on that are not directly applicable to the United States?

Dr. HAAS. Mostly the diseases that we call trypanosomal diseases. Trypanosomiasis, which I touched on here—African sleeping sickness—is an example. And I might say malaria could be included here, which we do not have as a major problem in this country except in the case of troops.

Another disease which we have studied in the laboratory is called leishmaniasis, which is present in Asia and South America.

Those are 3 or 4 examples which come to my mind. And we are concerned with a disease called amebiasis, sometimes called dysentery. Often we think of that as a tropical disease, and it is practically a disease of tropical countries and we like to think of it as such, but

the largest epidemic of that disease of record occurred in Chicago in 1932.

Mr. BUSBEY. I remember that instance at the Congress Hotel.

Dr. HAAS. It is the largest single outbreak that has been recorded—at the Congress Hotel; yes, sir.

HISTORICAL REASONS FOR RESEARCH ON FOREIGN DISEASES

Mr. BUSBEY. Is the activity with respect to diseases that are mainly applicable to countries outside the United States due in part at least to the fact we have so many Americans working in all parts of the world now under the various foreign aid programs?

Dr. HAAS. It is due to a number of factors. Much of this work was started years ago because of the general interest of science in public health in these so-called tropical or parasitic diseases. During World War II there was a tremendous upsurge of interest and great stimulation of research in all of these diseases, because we had so many troops abroad and because some of those diseases—for example, malaria—were considered to be absolutely critical at the outbreak of the war. A lot of that stimulation has carried over and gone along because of our interests in countries abroad, our financial cooperation, and so forth. It seemed to provide a natural stimulation for continuing many of the things that originated during World War II.

RELATIONSHIP TO WORK OF ARMED SERVICES

Mr. BUSBEY. Do not the armed services do a lot of research on these various diseases that are important to our military forces?

Dr. HAAS. Yes, sir; they do. And their work, of course, is limited to the problems as they concern the military. During World War II those problems were so extensive that they asked us to pitch in and help them out, since we had many competent people who could contribute. At the present time the military, of course, have done a lot of studies in the Korea region, and we have helped them out; we have taken part in some of those studies. But many of our studies are taking place in areas where the military are not directly concerned.

OTHER REASONS FOR WORK

Dr. SCHEELE. I am not sure the record is completely clear on some reasons why we are interested in these diseases. In the first place, this is not a very large or extensive program, but many United States people do travel abroad. Some are traveling abroad for pleasure, and they may go into areas where they develop amebiasis, and we do not have amebiasis normally as a natural disease in the United States. They come back to the United States and present themselves to our physicians here in terms of diagnosis. So one of the things Dr. Wright and his staff are doing in the Microbiological Institute is attempting to develop a skin test which physicians in the United States can use in diagnosing this obscure disease which patients come back with. We also have many United States commercial interests abroad. For example, one of our rubber companies in the United States has a very substantial development in Liberia, and there are considerable numbers of United States people there, not under Government

auspices but under private auspices, and these people in their work in those countries are exposed to this disease.

It is for those reasons, in addition to the fact it is very simple to do those things along side of things having to do with direct research on diseases at home or the spread of diseases at home, that lead us to do a small amount of work on these diseases.

I thought the record should show we do have concern with these diseases. It is not merely the occurrence of them abroad but the potential of getting them from our troops abroad, is a great one, and the program we conduct is carefully coordinated with the military program of research in these areas, so that we are not overlapping in the things we do. Each is doing research in the areas of its own special competence.

(The following statement was furnished for the record:)

TROPICAL DISEASE RESEARCH, NATIONAL MICROBIOLOGICAL INSTITUTE

This part of the program of the Institute would probably be better described as "parasitic diseases" research. We have had many occasions to regret our lack of basic knowledge in this field. The need is sometimes a military one, and then it is always acute. At other times we are concerned about introduction of foreign parasites into the United States and the establishment of the diseases they cause.

Schistosomiasis has become a serious disease problem in Puerto Rico; that country was once free from it. Filariasis was introduced into the United States by military personnel but, fortunately, it was kept from spreading. Malaria is being brought back to us from abroad, especially in discharged soldiers. Toxoplasmosis was first recognized in the United States about 15 years ago. An increasing number of cases have been reported yearly. The disease occurs most frequently in the new-born and often results in death or mental retardation. In a cooperative project with the Wilmer Institute in Baltimore, toxoplasmosis was found in 30 patients out of 170 suffering from chronic eye disease.

Research, stimulated by World War II, contributed directly to allied military victories. A short period of relatively little interest in some of these areas after the war was followed by renewed activity generated by military and refugee problems in Korea. Scientific competence is channeled now into lines that appear very promising. To slow down would mean that at some time in the future, when the need again becomes acute, we would realize that much of our progress to date had been dissipated.

FUNDS REQUESTED

Mr. BUSBEY. Your request for 1954 is $7 million?

Mr. HAAS. That is correct.

Mr. BUSBEY. How much did you request of the Bureau of the Budget?

Dr. HAAS. $7,999,000.

Mr. BUSBEY. The $7 million you are requesting is an increase of $1,520,800 over the amount estimated to be expended for the same purpose in 1953?

Dr. HAAS. Yes, sir.

BUDGET ESTIMATE FOR CLINICAL CENTER ACTIVITIES

Mr. BUSBEY. How much of your request is directly attributable to the opening of the clinical center?

Dr. HAAS. That figure is $556,350.

SECTIONAL RESEARCH PROGRAM

Mr. BUSBEY. Tell the committee a little more about the sectional research program mentioned in your general statement and also mentioned in the justifications.

Dr. HAAS. The sectional research program was conceived as a development which would utilize the voluntary participation of nongovernmental, non-Federal laboratories in improving our ability in the United States to diagnose and control more rapidly the infectious diseases. We feel in many instances there is knowledge which, if properly used, will enable the physician and epidemiologist to identify a given disease on its outbreak much more rapidly than is ordinarily done in peacetime civilian practice; that if a national emergency should arise where it should become necessary to increase our ability to do these things more accurately and more rapidly, we would want to be prepared to utilize all possible skills. Those skills reside over the country in the variety of laboratories in medical schools and hospitals and some in State and local governmental organizations. The sectional research program is designed to acquaint them with the need for their skills being more available, to stimulate their interest in collaborating with the physician and epidemologist, and to support by grants in aid research which these laboratories and scientists can conduct by reason of their competence—research which will make them even better able to do this sort of a job.

Mr. BUSBEY. Does this program help you deal directly with actual outbreaks of infectious disease?

Dr. HAAS. That is its purpose; yes, sir. I might say in respect to actual outbreaks, the communicable disease center, through its program called the epidemic intelligence program, which details epidemiologists to help in local and State investigational programs, is coordinated with our own which emphasizes the laboratory side, and their epidemiologists in the epidemic intelligence program may call upon the laboratory people in our program for collaboration.

EXPLANATION OF BUDGET INCREASES

Mr. BUSBEY. Explain to the committee briefly, if you will, why you think this $1,528,800 increase over the amount estimated to be expended in 1953 is necessary.

Dr. HAAS. In respect to the grants part of it, we have a great many more applications for worthwhile research than we are able to support. This would enable us, we feel, to take care of many scientific projects which merit scientific and technical support which, under present appropriations, would not receive that support.

In direct operations, our emphasis has been upon the many problems associated with the advance of scientific knowledge as they relate particularly to our biologics control responsibilities and the research that must be done in order that we can discharge those responsibilities.

Polio is an example. In polio within the past year we have witnessed the development of gamma globulin, which now is going to come into wide use. We need to develop from a fresh start methods for the control of gamma globulin so that when it is given to people we know it will do what it is supposed to do and know it will not do what it is not supposed to do. The whole impetus in the polio field has

increased tremendously. Most scientists now believe that within a few years we can expect a vaccine, and with that expectation comes the problem of making a certain quality of vaccine that, when produced and released, will be safe, will be active, will be dependable, and will do for the people what it is expected to do when physicians prescribe it.

That is only an example. Influenza is another one. We have the problem of influenza vaccine. In my testimony, I touched briefly on the fact that the type of influenza virus changes, sometimes from year to year, so that a vaccine which is good this year may not be effective next year if the virus changes slightly in its nature between now and next year. Here again, additional research is necessary so that we can have a vaccine upon which we can rely, which will be available to us on short notice.

The common cold and associated upper-respiratory diseases which you mentioned are another group which we feel merit more attention and we would like to give more emphasis to them.

RELATIONSHIP OF WORK TO "CONTROL OF COMMUNICABLE DISEASES"

Mr. BUSBEY. I am trying to get clear the line of demarcation between your Institute and "Control of communicable diseases." In the general statement for "Control of communicable diseases," on page 33 of the justifications, under the heading of laboratory activities, is stated:

> Laboratory collaboration with epidemiologic and other investigative activities, particularly the epidemic intelligence functions and airborne-disease studies is essential.

Those justifications go on discussing the number of laboratory diagnoses they have made.

Now you tell us that you are doing the work in that field.

Dr. HAAS. I did not mean to imply that at all, sir. Could I go off the record for a little in my testimony?

(Discussion off the record.)

Mr. BUSBEY. Now, if we might go back on the record, I am still just not clear why this is not under the division of control of communicable diseases. On the next page of the justifications, page 34, on communicable disease control, they also speak about the control of airborne diseases.

> The objective of this activity is to discover means by which civil populations may be protected in peace or in war from disease-producing agents disseminated through the air.

And then further down, they go into the vector-investigation-control activities. I may be entirely wrong, but it does seem to me there is an overlapping and duplication of activities here.

COORDINATION OF RESEARCH WORK

Mr. SCHEELE. Mr. Chairman, may I attempt to answer that since our view is the view above NIH, the microbiological program, and also the State services. Actually, these are integrated and coordinated programs. The study of airborne infections is actually a research project in which efforts are being made to study the mechanism of

spread and identification, the vectors—the study of animal vectors as means of transmitting disease, the insect which is intermediate between man and the next man—is again a problem which in the particular areas of the Communicable Disease Center are not being studied in the National Institutes of Health.

The sectional research program is desirable in our opinion because we do have occurring naturally in the United States changes in the forms of viruses or bacteria, or at least in our identification for the first time of a strain which possibly we have not known before, as today we know of a number of strains of polio virus whereas earlier we knew only there was polio virus. Each of these represents a problem of its own which requires laboratory work.

The sectional laboratory program is on the ready line to identify whether disease occurs naturally or because of an enemy action. It is prepared to identify with the best skill possible in the United States variance in the form of viruses or the bacteria which might be causing the problem. There is a research element in what we do. In addition, there is a service element in their identification since certain natural epidemics still occur. The laboratories participating in that program are among the most skilled in the country. They would play an exceedingly important role in protection, against both natural and enemy-caused disease.

PUBLIC HEALTH SERVICE COMMITTEE ON RESEARCH

In our opinion, there is not an overlap, duplication in the activities carried on under control of communicable diseases and the work going on in the National Institutes of Health. I point out further something which does not show in our justification, and that is that for many years now we have had in the Public Health Service a committee on research which is headed by a man who heads the Division in the Office of the Surgeon General, Mr. George Perrott, Division of Public Health Methods, on which sit members of the staffs of each of our bureaus; and it is the job of that committee to watch the programs in the Public Health Service, to review the research programs in the Public Health Service, and to watch for duplication and to work also with the question of determining whether it is appropriate for the Microbiological Institute to be in one field in a certain instance, or the Communicable Disease Center or the Environmental Health Center or some other branch of the Public Health Service to be concerned with the same problem. We are, I assure you, trying to avoid duplication and I think we are being reasonably successful.

(The following statement was furnished later, for the record:)

RELATIONSHIPS BETWEEN RESEARCH OF THE PUBLIC HEALTH SERVICE'S NATIONAL MICROBIOLOGICAL INSTITUTE AND ITS COMMUNICABLE DISEASE CENTER

I. BASIC MISSIONS OF THE TWO ORGANIZATIONS

A. Microbiological Institute

The basic objective of the National Microbiological Institute is to study microorganisms—amoeba, bacteria, rickettsia, and viruses—to determine their nature, growth, and reproduction requirements, life cycles, their effects on man, and ways in which man can be protected against them.

Scientists in these laboratories will undoubtedly produce findings useful in disease control in the future, as they have in the past. But the operation of

specific disease-control activities as public-health measures is not a function of these laboratories.

B. Communicable Disease Center

The basic objective of the Communicable Disease Center is to develop communicable-disease-control measures, to help States apply these measures, and to help train people in disease-control techniques.

In working upon communicable-disease control, unresolved problems requiring investigations and developmental work are often encountered and the staff of the Communicable Disease Center undertake this to solve these problems. But the conduct of research not directly related to the application of communicable-disease-control measures is not a function of this organization.

C. Work programs distinguished

This functional separation is analogous to the separation between research and production in an industrial concern. Both organizations may work on disease agents having the same names, but this is no more indicative of duplication than is the fact that an industrial research laboratory works on products that are later produced in the factory.

A control group must have close relationship with State and local health personnel. They must take imperfectly developed techniques and apply them, rather than wait for perfection. Their energies must be applied to practical tasks at hand. They must be prepared to work on problems presented to them with little notice and to accept these assignments as their job and not as an interruption.

A research group must be free of operating tasks, and their relationships are primarily with the scientific world. Their work will be most productive if they are not diverted to immediate problems of disease control. They must be permitted to follow ideas, even if it appears that they have no immediate practical value, for this is the way that knowledge will be acquired from which practical control measures will come in the future.

There are times when a sharp cleavage in functions is not possible. A first-class control operator will come up with ideas that he wants to try out. If capable control people are not given reasonable latitude to follow their ideas, the result will be mental stagnation and an inferior control program; hence, there is an element of research in the Communicable Disease Center which is not specifically tied to current control activities.

On the other hand, research scientists sometimes carry their ideas close to the point of application to control measures. It is impracticable and undesirable to draw a sharp line past which the investigator may not go in developing research ideas into measures applicable to disease control.

It is in the shaded areas referred to in the two preceding paragraphs that the Public Health Service takes administrative measures to see that the research institute does not move too far into the control area, and that substantial research programs not related to control are not established in the Communicable Disease Center.

WORK ABROAD DURING AND AFTER WORLD WAR II

Mr. FOGARTY. Doctor, was there not developed in the Public Health Service a few years ago a vaccine that will prevent typhus?

Dr. HAAS. Yes, sir; during the war a great deal of work was done on that.

Mr. FOGARTY. As a result of that discovery, I think it was testified here a few years ago that almost none of our troops in Africa or in any foreign country got typhus. We did not have any outbreaks in our armed services, did we?

Dr. HAAS. My recollection is that there were no deaths. There were some illnesses; no outbreaks in the usual sense of that word.

Mr. FOGARTY. Then I think someone testified here 2 or 3 years ago that as a result of this discovery and because of the vaccine that we were able to ship to, say, a country like Greece where typhus was rampant, we were able to get these people who were sick with typhus

on the job, and as a result increased the production in Greece. As another result we did not have to supply as much money as we might have had to under the Turkish-Greek loan. Is that not so?

Dr. SCHEELE. Yes, sir; that is correct. If I may go off the record——

(Discussion off the record.)

ASSISTANCE TO GREECE

Mr. FOGARTY. What are the details about the help we gave Greece? I do not know who it was that gave us that story 2 or 3 years ago.

Dr. SCHEELE. As I recall the story in Greece, there were several hundred thousand deaths each year from malaria and——

Mr. FOGARTY. Maybe it was malaria and not typhus.

Dr. SCHEELE. There was a typhus program, too. I do not recall the details of that. But through the use of techniques that have been developed, largely in the United States, for spraying mosquito-breeding areas and using DDT and other sprays, the deaths from malaria were brought down to figures in the hundreds. It was estimated that in the field of production of grain alone as much as 10 percent or more was added to the Greek indigenous supply by the control of malaria itself. Also it aided our industrial development to make themselves more efficient, more self-supporting.

In the case of typhus I do not know the figures, but the agricultural worker and even the town dweller were affected by the typhus problem there and again by the use of techniques developed here, using DDT and dusting the human body to kill the lice, typhus was brought down to literally the vanishing point and these people were made effective.

Mr. FOGARTY. Could you get us some more details on that and put them in the record?

Dr. SCHEELE. I believe we can.

(The information requested is as follows:)

MALARIA AND TYPHUS IN GREECE

A. MALARIA

Until recently malaria has been the No. 1 public health problem in Greece. It is estimated that prior to World War II, there were normally 1 to 2 million cases annually. During the years of heavy rainfall, there might be up to 3 million cases. From 1931 to 1936, the death rate from malaria was 74 per 100,000 population. This rate was 14 times higher than the malaria death rate in Italy which had the second highest incidence of malaria in Europe.

After the war UNRRA assisted the Greek Government in malaria control. When UNRRA came to an end, the Public Health Service, within the ECA framework, took over the program. This program consisted of: (1) Aerosol air-spraying of swamps and lakes, agricultural areas and other potential breeding places; (2) residual DDT spraying of the inside of houses; and, (3) ground larvaciding operations. From 1946 to 1950, 4,100 to 5,800 villages were sprayed annually and an average of 900,000 acres of potential breeding places were sprayed from planes. At the end of this period malaria was so well controlled that operations could be materially reduced.

It is estimated that there are now less than 50,000 cases of malaria a year in Greece. The number of deaths from malaria in cities with a population of over 5,000 fell from 1,856 in 1942 to 7 in 1951.

The General Directorate of Hygiene estimated that each case of malaria represented a loss of 20 man-days per annum, which is certainly a minimum. The annual loss due to malaria in terms of work was, therefore, from 20 million to 60 million man-days a year. Moreover the country consumed more than 33 tons of quinine annually at a cost of about $1 million.

At the height of operations in 1949 the malaria-control program cost $1,674,000; in 1952 the cost was estimated at $600,000. The return on this investment therefore, has been manifold, and has helped Greece immensely in its economic recovery.

It may be added that besides destroying malaria-carrying mosquitoes, the DDT spraying exterminated a huge amount of other insects, notably bedbugs and flies. Concurrently, there was a decrease in morbidity of other diseases such as intestinal infections. As a result of improved health conditions, the death rate in 1949 was 10.7 per 100,000 as compared with the prewar mortality rates of 15 per 100,000 during 1934–37.

B. TYPHUS FEVER

Louseborne typhus has never presented a major problem in Greece. The incidence naturally increased during the war and subsequently there were some outbreaks in the areas infested with guerrillas. Statistics for these areas are lacking. Dusting with DDT was carried out where necessary and the outbreaks were promptly controlled.

The inadequate official statistics, reported 688 cases of louseborne typhus in 1945; the figure fell to 130 cases in 1946, and 75 cases in 1947. During each of the years 1950 and 1951, when the whole country was covered, there were only three cases.

Murine typhus (fleaborne from rats) decreased at the same time from 588 cases reported in 1945 to 24 cases in 1951.

Mr. FOGARTY. That is all, Mr. Chairman.

Mr. BUSBEY. Thank you, gentlemen.

Dr. HAAS. Thank you, sir.

WEDNESDAY, APRIL 1, 1953.

NEUROLOGY AND BLINDNESS ACTIVITIES

WITNESS

DR. PEARCE BAILEY, DIRECTOR, NATIONAL INSTITUTE OF NEUROLOGICAL DISEASES AND BLINDNESS

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate (obligations incurred)			$7,670,000
Comparative transfer from—			
"Operating expenses, National Institutes of Health, Public Health Service"	$1,230,969	$1,537,300	
"Salaries, expenses, and grants, National Cancer Institute, Public Health Service"	119,446	170,000	
"Mental health activities, Public Health Service"	69,552	74,000	
"Salaries, expenses, and grants, National Heart Institute, Public Health Service"	142,259	191,000	
Total obligations	1,562,226	1,972,300	7,670,000

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
1. Grants for research and training:			
(a) Research projects	$1,276,587	$1,326,000	$4,328,000
(b) Research fellowships	50,918	150,000	150,000
(c) Training grants	52,702	58,500	210,000
(d) Training stipends	52,816	51,500	100,000
(e) Construction of research facilities			2,000,000
2. Direct operations:			
(a) Research	45,123	294,500	797,000
(b) Other direct operations:			
(1) Review and approval of research and training grants	18,471	22,000	22,000
(2) Administration	65,609	69,800	63,000
Total obligations	1,562,226	1,972,300	7,670,000

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Total number of permanent positions	9	36	66
Full-time equivalent of all other positions	1	2	2
Average number of all employees	7	25	55
Average salaries and grades:			
General schedule grades:			
Average salary	$4,496	$5,218	$4,509
Average grade	GS-6.7	GS-7.4	GS-7.1
01 Personal services:			
Permanent positions	$33,090	$145,140	$301,477
Part-time and temporary positions	3,400	8,850	16,200
Regular pay in excess of 52-week base	178	755	1,238
Payment above basic rates	532	1,705	2,085
Total personal services	37,200	156,450	321,000
02 Travel	7,796	11,300	14,900
03 Transportation of things	220	2,400	3,000
04 Communication services	1,048	2,500	4,900
06 Printing and reproduction	1,122	900	5,800
07 Other contractual services	4,812	10,700	10,700
Reimbursements to "Operating expenses, National Institutes of Health, Public Health Service"	51,005	187,150	473,000
08 Supplies and materials	7,229	6,400	29,100
09 Equipment	18,771	8,300	18,600
11 Grants, subsidies, and contributions	1,433,023	1,586,000	6,788,000
15 Taxes and assessments		200	1,000
Total obligations	1,562,226	1,972,300	7,670,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Obligations incurred during the year			$7,670,000
Deduct unliquidated obligations, end of year			3,985,000
Total expenditures (out of current authorizations)			3,685,000

Mr. BUSBEY. We now have for consideration the appropriation request for fiscal year 1954 for "Neurology and blindness activities." The committee will be very happy to hear from you at this time, Dr. Bailey.

GENERAL STATEMENT

Dr. BAILEY. Thank you, Mr. Chairman, members of the committee, first I should like to give my definition of the neurological and sensory disorders.

NEUROLOGICAL DISEASES DEFINED

As you may know, in general these are disorders of the nervous system and of the critical sense organs of vision and hearing. More specifically, they include a broad spectrum of different disturbances, such as cerebral palsy, multiple sclerosis, epilepsy, muscular dystrophy, Parkinsonism, and injuries to the brain and spinal cord. Among the sensory disorders are glaucoma, cataract, and many other conditions causing partial or total blindness and deafness.

Many people do not think of these disorders as a single group of diseases affecting a single organ: The nervous system and its important appendages, the eye, and the ear They tend to think of cerebral palsy, multiple sclerosis and other specific neurological and sensory disorders as distinct disease categories, lacking a common base. In a sense this is partially true, for they do have distinctive features. But for research purposes, we must group them all together and study them in terms of their common base—the nervous system with its sensory endings.

INCIDENTS OF DISORDERS

The nervous system is the most complex system of the body and also the most inaccessible to study. The reason is simple, the brain and spinal cord are encased in bony boxes which are not subject to surgical penetration without endangering either the health or even the life of the patient. But in spite of its relative inaccessibility to study, it is unfortunately particularly vulnerable to disease and injury.

As I reported to this committee last year, about 20 million Americans suffer from neurological and sensory disorders. Nearly half of these victims are seriously disabled. Moreover, these serious disorders frequently are permanent disabilities, for central nervous tissue—unlike other tissue of the body, such as the skin or liver—when once definitively damaged, never repairs spontaneously. For this reason victims of neurological diseases constitute a tremendous drain on the economy of the country—not only is there a manpower loss, but an additional burden is placed on local community and family resources.

STATUS OF RESEARCH

I should like very briefly to outline the present status of research in this field and describe the part that our Institute is playing in this endeavor.

Before the discovery of sulfonamide drugs and antibiotics, neurological research was concerned chiefly with clinical descriptions and autopsy studies. For example, only a few years ago a child with spinal meningitis might be so diagnosed, but was almost sure to die. I remember these cases well. At autopsy, the diagnosis was confirmed, and certain pathological observations were made. Nothing further was accomplished. Neurology during those times was not much more than a scientific cogitation on death.

Then, with the discovery of new drugs and penicillin, many of the infectious diseases of the nervous system were capable of being controlled. Neurosyphilis, a common scourge, was practically wiped out. Also virtually eliminated were bacterial infections of

the nervous system, such as epidemic meningitis and other brain fevers, and abscesses of the brain and spinal cord. Concomitantly, significant advances were made in surgery on the nervous system and the eye—advances which comprise one of the most dramatic chapters in the history of surgery. As you gentlemen probably know, the leading brain surgeon of all times was an American, Harvey Cushing, who died about 12 years ago. I bring this up because Cushing gave the United States world leadership in brain surgery and I bring it up particularly because there was a reason he did it. The reason he did it was because he put brain surgery in this country on a research basis. Cushing's surgeons were more than just surgeons. They were researchers and they maintained that leadership for this country, in my opinion, on this basis alone.

These achievements in infectious diseases and surgery, encouraging as they were, still left large areas of crippling neurological and sensory disorders untouched. Still unsolved were some of the worst neurological disorders of mankind—cerebral palsy, apoplexy, multiple sclerosis, muscular dystrophy, Parkinson's disease, the effects of brain and spinal-cord injury, including paraplegia, and loss of language functions. Among the sensory disorders, cataract, glaucoma, a type of early blindness of prematurely born infants called retrolental fibroplasia remained as serious problems.

To understand the basic mechanisms of these crippling disorders, a new experimental approach was badly needed to give us (1), precision instruments to make the nervous system and the eye more accessible to investigation, and (2), new experimental methods in fundamental neurological sciences to probe deeper into the basic nature of the structure, development, chemistry, and physics of the nervous system and its sensory endings.

Fortunately, in recent years, such an experimental approach has begun and is now gaining momentum on a wide front.

NEW PRECISION INSTRUMENTS

For example, during the last decade many ingenious precision instruments have been devised to make the brain, spinal cord, and optic nerve accessible to study by remote control. I shall not describe them all, but wish to mention one—the electroencephalograph—because of its prominent position in our research-grants program and in our own direct research activities.

The electroencephalograph is an electronic-precision instrument which records the tiny electrical beats of the brain, called brain waves. The brain waves of a healthy man or woman follow a standard pattern. But, in the case of a person whose brain has been damaged by injury or disease, the brain waves tend to deviate characteristically from the normal pattern. By measuring the brain waves in this way, the electroencephalograph has proved to be a valuable tool for the diagnosis and treatment of epilepsy and other brain disorders. To cite just one example: The study of the effects of different chemical agents on brain waves has enabled us to develop new drugs, through the administration of which about 80 percent of all epileptic seizures can now be controlled. I might add that only about 20 percent of the epileptics in the country receive this optimum treatment.

ADVANCES IN FUNDAMENTAL RESEARCH

The development of the electroencephalograph and other precision instruments has been accompanied by new discoveries in the basic biological sciences which now should be applied to research in the nervous system. To use the words of the present chairman of the National Research Council:

> The time is now ripe for * * * emphasis on the neurological basis of disease because recent discoveries in biophysics and biochemistry provide knowledge and experimental tools which open up new vistas.

Some of this newer knowledge already has been applied to neurological research; several promising clues have emerged as a result; and many of these clues are to be found in research projects supported directly or indirectly by this Institute. Let us consider just one of them.

REGENERATION OF NERVE TISSUE

A few minutes ago, I stated that tissue of the central nervous system, when once definitively damaged, could never repair. Recent research, however, shows that this principle no longer holds, at least as far as animals are concerned.

Last year, I reported to this committee that one investigator had demonstrated that by the use of a certain bacterial agent, cut nerve fibers in the spinal cords of animals could be regenerated and the structural continuity of the cut fibers reestablished.

At that time, however, no functional restitution was obtained. Although the cut nerve fibers regenerated and joined each other, the animal remained paralyzed. But, this year, another investigator reports some evidence of functional restitution in animals with severed spinal cords.

This work on the regeneration of nerve fibers is only one of the promising clues now discernible in fundamental research on the nervous system and the eye. There are many more. Though the findings to date are not yet conclusive, the time has come to press the attack.

I would like to give another example from a letter of a grantee we just received, that he has succeeded in obtaining action potentials from nerve cells grown in vitro, in a test tube. This indicates that it might be possible to grow nerve cells outside of the body. As we all know, to gain anything in research it is necessary to be able to grow the object and then test the effects of various noxious agents on the object.

Excuse me for the digression but it was so exciting I could not resist.

REHABILITATION

Until these studies in fundamental neurological research produce practical results, the only help now available for these crippling disorders is rehabilitation. Rehabilitation is simply a comprehensive system of therapeutics whereby a patient with a chronic disability is trained through specialized techniques to use to the maximum what he has left in order that he may attain the highest possible degree of self-care, productivity and social adjustment. For example, most of us learn to speak with only half of our brain. If the part of the brain

used in speech is destroyed by injury, we then lose the power of speech. Here, the rehabilitation problem is to train the patient to learn to use the healthy half of his brain to regain his power of speech.

As I mentioned last year, about 75 percent of all neurological disorders can be rehabilitated to varying degrees of self-care and gainful employment. However, the rehabilitation field is still a new one and comparatively untouched by research into how present rehabilitation methods and techniques can be made more effective.

GRANTS FOR RESEARCH PROJECTS

So far, Mr. Chairman, I have endeavored to give you a general view of the background of our Institute and the national status of research and training in neurological and sensory disorders. I would like now to outline briefly the major parts of our program and some of our critical needs which must be met if we are to realize our objectives.

The largest part of our program is devoted to research grants-in-aid to universities and other non-Federal institutions. During the current year, the Institute has had a total budget of $1,326,000 to support scientific investigations in neurological and sensory disorders. This figure covers the support of some 140 research projects in 56 scientific institutions. These research projects are directed toward the cause, diagnosis, prevention, treatment, and control of serious neurologic and ophthalmic disorders already named, while others are directed toward fundamental neurological and ophthalmic research which might provide clues to the cause or causes of these disorders.

Because of the multiplicity of neurological and sensory disorders, the need for research grant support in this field far exceeds the present resources of the National Institute of Neurological Diseases and Blindness. For example, at its February 1953 Council meeting, our National Advisory Council recommended almost half a million dollars of research grant applications which had previously been screened and recommended for support by study sections. It is a wry testimony to the needs of our Institute that we shall be able to lend financial research support only to the extent of our remaining $6,000.

TRAINING GRANTS PROGRAM

I should like to emphasize again before this committee the urgent need for better facilities in the postgraduate training of clinical teachers in neurological and sensory disorders. As you fully realize, research and training are merely different points on the same assembly line. Both points must be continuously active if a constructive research program is to endure. Unless the scientist in the laboratory can rely on a pool of young scientists in training, his program will not survive for long. Similarly, if there is not a source of young clinical researchers in training, important laboratory discoveries may remain concealed for years before they can be tested in the clinic.

With minor exceptions, the current facilities in our medical schools for postgraduate training of teachers in neurological and sensory disorders are seriously inadequate. Only about a third of all the country's medical schools have complete neurological units for teaching physicians and scientists. Many of our neurological teachers

are not qualified neurologists, and many States in the United States do not have a single qualified neurologist.

At present, our Institute is affording some relief to this situation by supporting postgraduate training grants in neurology in six medical schools. Additional requests for this sort of assistance, based on carefully evaluated needs and in terms of available personnel, have been received from over 50 additional teaching institutions. It is the opinion of our National Advisory Council that this part of the program deserves the highest priority.

GRANTS FOR RESEARCH FELLOWSHIPS

Besides the training-grants program, our Institute has a research fellowship program which supports 36 postdoctorate and special fellows in the broad fields of neurology, ophthalmology, otology, neurological rehabilitation, and neurological surgery. At present we are able to support only about 1 of every 6 highly qualified applicants for training in this important field of investigation. I might add that at our last fellowship meeting we were able to award only 2 out of 30 applications.

TRAINING STIPENDS

The final part of our postgraduate training program concerns stipends, traineeships, to increase the number of highly trained personnel who will develop into competent teachers of the clinical and rehabilitation aspects of neurological and sensory disorders. Currently, we are supporting 20 such trainees. An additional 20 highly qualified individuals could be placed immediately.

FINANCING OF INSTITUTE

The National Institute of Neurological Diseases and Blindness is the newest of the National Institutes of Health, having been created in response to public and professional demand by Public Law 692 in August 1950—2 months after the onset of the Korean conflict. No appropriation was made available to activate the Institute until fiscal year 1952, when $1,250,000 was made available to initiate a program of research. These funds were made available within the general appropriation "Operating expenses, National Institutes of Health, Public Health Service, 1952."

The $1,972,300 appropriation for the current fiscal year provides for essentially the same very limited program as the previous year, with the bulk of the money going to the support of research activities in medical schools and universities. To further the original plans of the Institute, and to capitalize on expenditures to date, the budget materials before you for the first time carry the National Institute of Neurological Diseases and Blindness as an identifiable appropriation item.

CLINICAL-CENTER PLANS

In closing, Mr. Chairman, I would like to say that we have the opportunity of launching the first full-scale coordinated research program in the world against neurological and sensory disorders. I am referring to the laboratory and clinical facilities of the clinical center.

We have for the first time the opportunity to investigate these disorders with the latest precision tools and to coordinate the data they yield with our rapidly increasing knowledge in the basic biological sciences. Here, there should be no delay between laboratory discoveries and their application to clinical problems.

Off the record, please, Mr. Chairman.

(Discussion off the record.)

Dr. BAILEY. The funds included in this budget will provide a small basic laboratory staff for work on neuroanatomy and developmental neurology and a small laboratory for investigations on the special senses, particularly the eye and the ear.

The clinical-investigations staff will have a large responsibility in activities of the clinical center, since the Institute, in addition to its own important research program, is responsible for consultation and clinical services in neurology, neurosurgery, audiometry, rehabilitation, electroencephalography, and ophthalmology to all the Institutes.

The neurology and blindness program of research has already shown great potentiality in a very short period of time. I hope we will be given the opportunity to press forward, because research in this important field will yield rich dividends.

I am grateful for the chance to appear before you and explain our work and our plans; and I shall be pleased to answer any questions you may have.

BASIS OF BUDGET ESTIMATE FOR GRANTS PROGRAM

Mr. BUSBEY. On page 7 of your statement, Dr. Bailey, you mention that the need for research and grant support in this field far exceeds the present resources of the National Institute of Neurological Diseases and Blindness. Could not the same thing be said of almost every research endeavor, whether it be medical research, agricultural research, physical research, or any other research?

Dr. BAILEY. I think that is probably true, Mr. Chairman, but I think it is particularly acute in our Institute. If you like, Mr. Chairman, I could give you a breakdown of our situation in our research, how we arrive at the figures we do.

Mr. BUSBEY. Please do so.

Dr. BAILEY. For instance, in the estimated backlog of 1953 research grants, at the council meetings, we had $340,000 in unpaid recommended grants. In the February council meeting, we had $400,000 in unpaid recommended grants, and an estimate in the June council meeting based on the proposition of the excess in June over the other council meetings of $1,528,000, making a total of $2,268,000. In addition to that, for the continuation of the 1953 grants—that is, to continue 80 percent of 1953 grants through 1954, which is the usual ratio—we have the figure of $1,060,000. That means, with the new budget of $4,328,000, we will have available for new grants $1 million. That is the 1954 President's budget; but, as you see, the backlog—that is, the grants that came up during the previous years—was more than double that amount of money. I mentioned in my statement that at the last council meeting we had half a million dollars of recommended grants of high priority and $6,000—not $60,000 or $600,000, but $6,000—to pay these recommended grant applications.

Mr. BUSBEY. I believe you mentioned that you were only able to take care of 2 out of 30 recommended grants?

Dr. BAILEY. That was in research fellowships.

Mr. BUSBEY. Had all 30 of those been screened and approved?

Dr. BAILEY. Yes; they had. As you may know, we have a priority list from 1 to 5, and the terminal point was around 2. Anybody with priority below 2 could not receive a grant; 2 was a high priority.

TOTAL FUNDS REQUESTED FOR 1954

Mr. BUSBEY. Your request for 1954 is $7,670,000?

Dr. BAILEY. Yes, sir.

Mr. BUSBEY. What was your original request of the Bureau of the Budget?

Dr. BAILEY. It was $9,499,000.

Mr. HARLOW. That did not include the $2 million research grant construction item, Mr. Chairman.

Dr. BAILEY. That would have made it $11,499,000.

Mr. BUSBEY. The $2 million construction item was added later?

Dr. BAILEY. That is correct. So, actually, the actual request was $9,499,000, which represents an increase, the increase being mostly in the area of research grants.

Mr. BUSBEY. And the Bureau of the Budget allowed how much, including the $2 million for construction?

Dr. BAILEY. $7,670,000 was the total figure allowed by the Bureau of the Budget, the 1954 budget figure.

Mr. BUSBEY. That $7,670,000 includes the $2 million for construction?

Dr. SEBRELL. That is right.

COMPARATIVE TRANSFERS

Mr. BUSBEY. Would you briefly explain to the committee the comparative transfers from cancer, mental health, and the Heart Institute? The justifications state that these transfers relate to grant funds, but what kind of projects are involved?

Dr. BAILEY. The type of projects involved were of interest to both institutes but probably most likely of primary interest to the Neurological Institute because of the involvement of the brain and spinal cord, or eye, in these projects. From the Cancer Institute there was a tranfer of $170,000, $191,000 from the Heart Institute, and $74,000 from the Mental Health Institute which was not research projects but those were the 6 grants for the training of neurological and sensory disorder teachers in medical schools. These previously had been carried by Mental Health but they were for neurologists, for the training of neurological people.

REQUESTED FUNDS FOR CLINICAL CENTER ACTIVITIES

Mr. BUSBEY. How much of this appropriation is directly attributable to the opening of the clinical center?

Dr. BAILEY. The net increase is $410,450, and the total amount for the clinical center is $579,100.

HERPES ZOSTER

Mr. BUSBEY. Tell us what herpes zoster is that you refer to on page 180?

Dr. BAILEY. Herpes zoster is an infection, presumably a virus, but the origin is not known, the cause is not known. It attacks the nerve roots; that is, the nerves after they come off from the spinal cord into the ganglia and before they go to other parts of the body. It is chiefly of the sensory nerves and with it as soon as this attack begins, we usually have very characteristic skin lesions. The common form is known as shingles. You have probably known people who have had shingles.

The lesion is usually around the center of the body, but it is not limited to that. It can involve the nerves of the face and also the eye, producing blindness. It is an extremely painful disease in those locations. Frequently, even after the skin lesions disappear, patients have an excruciating pain called postherpetic pain; and not a few people have committed suicide as a result of this pain. It is often impossible to control. All types of surgical operations have been tried, including operations on the spinal cord, the brain, actually cutting the cranial nerves from the source, but still, in many cases, the pain remains. And it is a very great problem. By the way, it is quite frequent, if you list it as a common skin disease, it is 2 percent of all skin diseases.

WORK OF VOLUNTARY AGENCIES

Mr. BUSBEY. Tell us about the work of private organizations operating in this field?

Dr. BAILEY. Well, this field, I described as a broad spectrum. The result is that in neurology you have 7 voluntary health agencies and in blindness, 3 in particular, that are interested in research.

Mr. BUSBEY. Would you name those for us, please?

Dr. BAILEY. In neurology, you have the National Multiple Sclerosis Society, the National Epilepsy League, the Committee for the Understanding of Epilepsy, the National Society for Crippled Children and Adults, the Muscular Dystrophy Associations of America, the United Cerebral Palsy Association, the Multiple Sclerosis Foundation of America, the Myesthenia Gravis Foundation, which was just recently formed; and in blindness, you have the American Foundation for the Blind, the National Society for the Prevention of Blindness, and the National Council To Combat Blindness.

Now, there are about 50 other societies for the blind but they are more concerned with welfare than they are with research. Indeed, these societies, these three that I mentioned, are also concerned with the welfare of the blind patient. This creates a bit of a hodgepodge if I may say so, but fortunately, at least as far as the neurological societies are concerned, recently they formed a national committee called the National Committee for Research in Neurological Disorders of which the chairman is a physician, neurologist, professor of neurology at the University of Minnesota. Now, the purpose of this committee is to survey the needs in this field, and to see if some sort of national program cannot be devised among them, so that as far as their research funds are concerned, they will not be overlapping, there will

not be duplication, and there will not be support of worthless projects.

I might say with reference to money that the amount of money spent for research by those seven voluntary agencies is about a third of the amount of money spent by our institute for research projects at the present time.

EXPENDITURES OF VOLUNTARY AGENCIES

Mr. BUSBEY. Do you have any figures available that show the amount of money that they raised, let us say, in 1952, and how it was spent for research and other projects?

Dr. BAILEY. I can supply those for the record if you like, Mr. Chairman. I do not have them with me.

Mr. BUSBEY. It would be helpful if you would.

Dr. BAILEY. I can tell you the largest percentagewise is the National Multiple Sclerosis Society. The second largest is the Cerebral Palsy Associations. Also very high in research interest is the Muscular Dystrophy Associations. Now, the National Society for the Crippled Children and Adults, up to 2 years ago, gave practically nothing for research, but recently they are trying to divert about 10 percent of their budget for research because that naturally requires the support of the local chapters, which they are obtaining, or at least trying to obtain right now. With reference to the National Multiple Sclerosis Society, the amount of their budget that goes into research is about 60 percent.

(The matter referred to above is as follows:)

Total funds and funds allocated for research from voluntary health agencies interested in research in neurological and sensory disorders

	Total funds available, 1951	Funds for medical research, 1951	Percentage of total for research
National Council to Combat Blindness, 1948	$46,179	$26,190	56.7
National Society for the Prevention of Blindness, 1944	217,524	34,219	15.7
American Hearing Society, 1944	75,863	None	0
Muscular Dystrophy Associations of America, 1950	191,000	98,000	51.3
National Epilepsy League, 1948	(1)	(1)	(1)
National Multiple Sclerosis Society, 1946	190,321	119,531	62.8
National Society for Crippled Children and Adults, 1944	6,100,330	77,416	1.3
United Cerebral Palsy Associations, 1949	2,133,000	107,875	5.1
Myasthenia Gravis Foundation, 1952	(1)	(1)	(1)
Committee for Public Understanding of Epilepsy, 1951	100,000	None	0
National Committee for Research in Neurological Diseases, 1952	(1)	(1)	(1)
American Foundation for the Blind, 1944	528,581	285,089	53.9

[1] No figures available.

COORDINATION OF VOLUNTARY RESEARCH ACTIVITIES

Mr. BUSBEY. I can appreciate the fact that there would be some advantages if these organizations were to combine into one large organization, but I can also understand why they would wish to maintain separate organizations because certain individuals were interested in starting them because in a great many instances of the particular affliction hitting their family.

Dr. BAILEY. There is a positive element in this newly formed national committee. That union is only for research and they all know that research in one neurological disease might give us the answer to another. So, if they have a nationally coordinated program for re-

search, including a lot of neurological diseases, for instance, like Parkinson's disease, of which we have a million and a half cases, but no representative society, and if they take up their needs, too, then they really have a national program, at least on paper.

LACK OF KNOWLEDGE REGARDING NEUROLOGICAL DISEASES

Mr. FOGARTY. Dr. Bailey, as I see it, this program is different from many of the other research programs. One could almost say that your Institute deals with the forgotten people. I mean by that, that people generally are, or at least have been, terribly ignorant of neurological diseases. I never knew what multiple sclerosis was until I met a young fellow from Rhode Island down here at a banquet. He had two canes. I asked him what his trouble was, and that was the first time I had ever heard of multiple sclerosis. I know that there are millions of people in this country who have never heard of that disease. When I became aware of that particular disease 4 or 5 years ago I began asking some questions and found that we were spending hardly anything on research—$30,000 or $40,000, I think—on neurological diseases. We did not even know at that time how many people were affected by such diseases or how many people died of them; there were no statistics kept at all. So I think those people were just being forgotten. As I understand it, multiple sclerosis is a very progressive disease; is it not?

Dr. BAILEY. Yes, sir.

Mr. FOGARTY. Up to this point, there is not much you can do to help its sufferers?

Dr. BAILEY. That is true. I would like to add that the reason they are forgotten, particularly multiple sclerosis and other neurological diseases, is that their symptoms are not socially acceptable. If a man is paralyzed, if he cannot talk, if he has epileptic fits, if he has uncontrollable tremors or body movements, he tends to withdraw and hide, sort of behind an iron curtain of social despair. The result, for instance, in epilepsy where the stigma is highest, is that it is difficult to get any members of a board of a voluntary society for epilepsy to put their names on stationery, because nobody wants to think that they have a particular interest in epilepsy.

Mr. FOGARTY. It wasn't very long ago that when anyone went into a mental hospital, they never wanted it known that they were ever in, but some of the people I know who have been in and out of such hospitals and are apparently all right now have been educated to talk about it, not hide it or keep it to themselves, and that has helped in the rehabilitation of these people. I suppose you will have to do the same thing with epileptics and other persons affected with these neurological disorders.

Dr. BAILEY. That is very true, Mr. Fogarty. It was even true of cancer at one time.

RESEARCH ON MULTIPLE SCLEROSIS

Mr. FOGARTY. Has any headway been made with respect to multiple sclerosis?

Dr. BAILEY. Well, right now a lot of work is being done on multiple sclerosis. As to the cause of the disease, I should say that no progress

has been made other than a general tooling up. As you know, multiple sclerosis is caused by a dissolution of the sheath that surrounds the nerve fibers, particularly in the spinal cord and certain parts of the brain. This sheath which is called the myelin-sheath, we do not know the chemical nature of it. At autopsy, we can spot a case of multiple sclerosis easily. We do not know what happened or what caused it. Now we hope to do this: we are going to take up this problem at the clinical center, to get at the chemistry of the formation of the myelin-sheath to see what can form it, what can destroy it. I think there are some leads in that direction. I think that is where the ultimate explanation is. As far as treatment is concerned, we have nothing that I know of that is an effective treatment of multiple sclerosis because it is a progressive disease. Through rehabilitation they can be helped perhaps to be productive during remissions for a certain length of time. But you lose the battle in the end because the disease is progressive.

Mr. FOGARTY. It strikes people right in the prime of their youth—in their thirties and forties, does it not?

Dr. BAILEY. The age range of multiple sclerosis is between 20 and 40. That is true of many of the neurological diseases, that they hit children and people in the prime of life. Of course, cerebral palsy is the most common of the diseases among children.

MUSCULAR DYSTROPHY

Mr. FOGARTY. What about muscular dystrophy? Is it similar to multiple sclerosis?

Dr. BAILEY. It is not similar from a pathologic standpoint. Muscular dystrophy is a dystrophy, is a disease in which, as far as we know, right now, the basic pathology is in the muscle rather than the nerve, though there may be some influences from the nerve causing the reaction in the muscle. But the result is a progressive paralysis of the flabby type whereas multiple sclerosis is a stiff type of paralysis.

Mr. FOGARTY. You do not know what causes muscular dystrophy, either?

Dr. BAILEY. We have no idea.

Mr. FOGARTY. There is no cure?

Dr. BAILEY. No cures. About a third of the cases of muscular dystrophy die in a rather short time.

CEREBAL PALSY

Mr. FOGARTY. Now, I understand you are making some progress in the treatment or rehabilitation of patients suffering from cerebral palsy?

Dr. BAILEY. Yes; that really pays off because cerebral palsey, or at least most cases of cerebral palsy, are not progressive. We know it will not go farther. Then we can develop substitute functions.

Mr. FOGARTY. You also know some of the causes of cerebral palsy?

Dr. BAILEY. Yes; we do. For instance the Rh factor of the blood is one cause. That is one thing it can be caused by.

Mr. FOGARTY. What do you mean by Rh blood factor—where the mother is positive and the father is negative?

Dr. BAILEY. Incompatible elements of the blood, and the foetus become allergic to the incompatible elements, resulting in destruction of blood cells.

Mr. FOGARTY. We can do something about that if it is known at birth, can we not. Can't we change the blood?

Dr. BAILEY. Very true; by exchange transfusions. You also can change the marriage as far as that is concerned, people about to get married.

Mr. FOGARTY. What do you mean?

Dr. BAILEY. If there is a blood incompatibility as far as the Rh factor is concerned.

Mr. FOGARTY. Advise them not to get married?

Dr. BAILEY. Not to marry a certain person.

Mr. FOGARTY. I do not understand.

Dr. BAILEY. Take somebody that wanted to marry somebody else and the blood compatibility was not advisable as far as having children was concerned, would result possibly in getting cerebral palsy, we could advise them that it would be better to choose another mate.

Mr. FOGARTY. That is not very effective advice, is it?

Dr. BAILEY. Not at all effective.

Mr. FOGARTY. Are babies not sometimes harmed at birth by the instruments of doctors? Is that not possible?

Dr. BAILEY. That is quite possible.

Mr. FOGARTY. That is one area that could be helped, is it not? That is, the delivery of the child?

Dr. BAILEY. That is true. Also, what we are investigating and where probably a lot of cerebral palsy comes from is from the question of various noxious influences on the fetus, on the mother which react on the fetus before the child is born.

Mr. FOGARTY. Do you know that is happening at the time it happens?

Dr. BAILEY. It is being investigated now. We have several grantees working in that field.

CONTROL AND TREATMENT OF EPILEPSY

Mr. FOGARTY. You have made some definite progress in epilepsy, have you not?

Dr. BAILEY. Often we can control epilepsy; the individual can be made productive and working; about 80 percent of all epileptic seizures we can control. We do not, though, because not enough doctors know about the optimum treatment; only about 20 percent of the epileptics are receiving such treatment.

Mr. FOGARTY. About 60 percent could be cured or could be returned to productive employment if the knowledge and equipment were available all over the country; is that what you mean?

Dr. BAILEY. I should say it would be about 70 percent. You see, there is another factor there, the factor of employment. A lot of industries and even Government agencies do not wish to employ epileptics because of the social stigma involved. They do not want—they are afraid the epileptic might have a fit and that people working around them might react negatively to the scene. So we have the problem of employment; even though his fits are controlled, a patient with history of epilepsy often cannot find employment.

ELECTROENCEPHALOGRAPH

Mr. FOGARTY. What do you call the machine used to find some brain disorders?

Dr. BAILEY. It is an electroencephalograph. It is an electronic precision machine in which electrodes are placed on the scalp of a patient and these electrodes record potentials that are actually coming from his brain. By means of amplifiers, they are amplified over a million times. They are transmitted and actually the brain waves are recorded by inkwriters on paper. The average person has a standard pattern of brain waves whereas with epileptics or somebody with a local brain lesion, you would see abnormal discharges coming out and you could say something about the nature of these discharges and where they are coming from. It is also used quite extensively in the localization of brain tumors. It likewise presents a very great advance in treatment because you can test the effect of your medication through the electroencephalograph.

Now, an epileptic, to have an abnormal electroencephalogram, does not have to have a fit when you are running the record. These seizure discharges come out even when he is not having a convulsion. By the character of the tracings you can pretty well regulate and pick the type of medication you are going to use. It has been an enormous step forward, but recently I said 80 percent of epileptic seizures could be controlled; how about the 20 percent that cannot? Well, most of these are due to local brain lesions. Sometimes they can be helped by doing an operation. With your scalp electrodes, you find the general area from where the abnormal discharges are coming, then you turn a bone flap in the skull, go in and expose the brain. Then you use cortical electrodes that you place in various parts of the brain until you find the maximum area of discharge. Then when you find the maximum area of discharge, though you may not actually see anything wrong with it, nevertheless you extirpate or cut out that portion of the brain, and usually that is the portion that is causing the seizures.

Mr. FOGARTY. Why are not there more of these instruments in use throughout the country?

Dr. BAILEY. I think largely because the value is not appreciated, and they are expensive.

Mr. FOGARTY. What do they cost?

Dr. BAILEY. About $4,000. For instance, Children's Hospital, in Washington, has just succeeded in getting an electroencephalograph. It is one of the largest children's hospitals in the world. It took them 5 years of very hard campaigning to get just 1 electroencephalograph, and they have about 10,000 epileptic patients in this area. It took them 5 years after very, very intense efforts, including a drive, to raise enough money for that.

Mr. FOGARTY. Are there many areas in the country that do not have this machine?

Dr. BAILEY. Very many.

Mr. FOGARTY. Many States that do not have it?

Dr. BAILEY. I should say there were six States that do not have any. That is an estimate. I have never surveyed the actual thing, but can estimate from the demand that I hear about, and also from requests that come in to us.

Mr. FOGARTY. How long has this machine been in operation?

Dr. BAILEY. This machine has been in operation, well, let's say in effective operation for about 10 years or 15 years.

WORK ON BRAIN TUMORS

Mr. FOGARTY. What about brain tumors? There has been some progress made in surgery and new techniques, has there not?

Dr. BAILEY. Remember, I spoke of Harvey Cushing? Cushing actually started a classification of brain tumors so you could tell a malignant tumor from a nonmalignant tumor, one that was operable from one that was not operable. You could do it pathologically through frozen sections taken at the operation if you had a neuropathologist to examine the section. The trouble is that there are only about 15 in the country, good ones. Then the tumor, if it was nonmalignant—first of all, a primary tumor of the brain is not cancer although cancer can go from other parts of the body to the brain, yet histologically a primary brain tumor is not a cancer.

Mr. FOGARTY. What is it that is sometimes called a malignant tumor?

Dr. BAILEY. That means it is infiltrating and goes through all parts of the brain and is not encapsulated. A benign tumor is one that can be scooped out. The malignant tumor infiltrates the tissue of the brain so you have no line of demarcation to cut it out, and then almost invariably they recur even though you take out the majority of them.

Now, the malignant tumors are about 50 percent of all brain tumors.

Mr. FOGARTY. And they generally recur after you operate?

Dr. BAILEY. They almost invariably do, the malignant type.

Mr. FOGARTY. Up to this point, operating on a malignant tumor cannot offer more than temporary relief?

Dr. BAILEY. Previously, you could not even operate on the benign tumors. Now they are successfully removed, and particularly where a big stride has been made is in the subject of haematomas which are blood clots, what they call subdural haematomas outside of the brain, but pressing on it. That is sort of a clot and is almost certain death if it is not recognized and removed. If it is recognized, you chances for complete recovery are about 90 percent if surgically removed. I have seen a lot of these haematomas in my life and of the ones that I have seen that came to post mortem—about 50 percent were not diagnosed due to lack of qualified people to diagnose them.

Mr. FOGARTY. If they were diagnosed properly, they could be operated on.

Dr. BAILEY. A professor of medicine of a very large medical school was taking a shower in the bathtub, fell down, and forgot all about it. Then his mind began to wander a little bit. He was examined and sent to us. We found certain local neurological signs and observed the fact that he was going in and out of varying states of consciousness. We diagnosed it as subdural haematoma; operated on him with local anesthesia; and discussed everything during the operation. I don't know whether it was 15 years ago or not; but he is still professor of medicine at this medical school; in very good health.

GLAUCOMA

Mr. FOGARTY. If that had not been diagnosed properly, he would not be here today.

What are you doing in the field of blindness? Are there more cases of glaucoma?

Dr. BAILEY. I don't know that there are more cases, but it still is a very large problem, about 10 percent of eye diseases, and we do not know the causes of it.

Mr. FOGARTY. Does that happen when a person is young, middle-aged, or old?

Dr. BAILEY. It can happen at any age, but more frequently as a person gets older.

Mr. FOGARTY. You can't do much about it?

Dr. BAILEY. Well, there are operations, but it is still a very serious thing. It is a threat to sight and the most serious part is that we do not know anything about it—why it starts.

OTHER BLINDNESS ACTIVITIES

Mr. FOGARTY. What other work are you doing in connection with blindness?

Dr. BAILEY. We are doing work on cataracts; we are working on this disease shown as retrolental fibroplasia.

Mr. FOGARTY. In children?

Dr. BAILEY. Prematurely born children, and there are more today because of the lifesaving measures of medicine, and these children, as they grow older, develop a detachment of the retina followed by blindness. The cause of that, we know, is that it is associated with premature births. The actual cause is not known. For a while it was thought that maybe the oxygen given to the child at birth might be responsible because they were given an increased oxygen. That has not been proved or disproved. We are investigating it right now.

SUPPLY OF QUALIFIED NEUROLOGISTS

Mr. FOGARTY. Now, you mentioned in your statement that there are some States that do not have qualified neurologists.

Dr. BAILEY. Yes.

Mr. FOGARTY. What is a qualified neurologist?

Dr. BAILEY. A qualified neurologist is one who is certified by the Board of Neurology and primarily interested in neurology.

Mr. FOGARTY. How many are there in the country?

Dr. BAILEY. About 250.

Mr. FOGARTY. Only 250 in the country?

Dr. BAILEY. That is correct.

Mr. FOGARTY. What is being done to get more people interested in neurology?

Dr. BAILEY. Well, a lot of people are interested, but there is nothing to support them right now. We have now 50 requests from different medical schools for assistance to develop teachers. We are not interested in developing practitioners but teachers to place in medical schools who can teach neurology to physicians and give them a research orientation. We have spontaneous requests from 50 schools.

There are six schools that I know of that are looking for a head of a department but cannot find one.

Mr. FOGARTY. How many medical schools teach neurology?

Dr. BAILEY. We should say—at least, I should say—how many schools have facilities.

Mr. FOGARTY. How many schools have facilities for teaching neurology?

Dr. BAILEY. About 20 percent.

Mr. FOGARTY. Twenty percent of the approximately 70 schools?

Dr. BAILEY. Some people say 3 percent, but I say 20 percent.

Mr. FOGARTY. That is another reason people afflicted with these diseases should be classified as forgotten people.

Dr. BAILEY. That is right. For instance, the average time of diagnosis of a case of multiple sclerosis is 6 years.

IMPORTANCE OF MEDICAL RESEARCH

Mr. FOGARTY. The only way we are going to get an answer to some of these things is through research, is it not?

Dr. BAILEY. I am certain of that.

Mr. FOGARTY. You have to find the cause in order to find a cure?

Dr. BAILEY. As with epilepsy, we may reach control in some of these diseases without knowing the cause. We know not the cause of epilepsy.

Mr. FOGARTY. In multiple sclerosis or muscular dystrophy, you don't know the causes or a way of controlling them either.

Dr. BAILEY. If these experiments on regeneration of nerve tissue turn out, for instance, you have an accident, injury of a nervous system, 6 percent of all accidents, civilian and warfare. Now, when it is once injured, nervous tissue does not regenerate. But if we find a way to regenerate it, then it will be no longer that kind of problem.

Mr. FOGARTY. Sometimes we find it difficult to convince some Members of Congress that appropriations for medical research are necessary and are accomplishing results. Some of them argue, sometimes on the House floor, that we are throwing money down a rathole by appropriating funds for research. What do you think about it?

Dr. BAILEY. Well, I disagree with that wholeheartedly.

Mr. FOGARTY. I do too, but how are we going to convince people who think we are not making any progress that we are not wasting millions in this field? I am talking about the entire health field.

Dr. BAILEY. It seems to me the only way is to get the story to the public and, of course, science or scientists cannot carry the story to the public.

Mr. FOGARTY. I know that.

Some of the biggest manufacturers in the country spend millions of dollars a year for research. For example, it has been said that Standard Oil of New Jersey spends $20 million a year in trying to develop a better high octane gasoline. I am confident that such a business would not be spending $20 million on research were it not believed that the research would produce tangible and profitable results. Similarly, as soon as a disease like hoof and mouth breaks out, the Government spends millions of dollars in an effort to stamp out the disease. In this instance, a great deal of money was spent in a

foreign country, Mexico. That appropriation was passed with no trouble at all because it affected the farmers' pocketbook.

Mr. BUSBEY. Is that research or destruction?

Mr. FOGARTY. Destruction. But at the same time we are building a new research laboratory for hoof-and-mouth disease. The original plans a couple of years ago called for $25 million for that purpose; I haven't heard recently how much is actually being spent.

Dr. BAILEY. I might interpose that the development of the electroencephelograph cost $300,000.

Mr. FOGARTY. When disease strikes the elm trees, everybody gets upset about it and wants something done about it right away. I am not opposed to that. I think it is a good thing. I am for it, too. But it has always seemed to me that we ought to do a little more than we are doing in the field of medical research on human beings. None of us are immune to any of these diseases we have been discussing; are we?

Dr. BAILEY. Nobody in this room.

Mr. HARLOW. I think your observation is borne out by the fact that on a good many farms the barns are the most well-kept buildings on the place.

Mr. FOGARTY. That is right. I think sometimes one is inclined to think more of his dog and horse than of himself.

Dr. SEBRELL. I doubt if there is a large corporation in this country today that does not have some kind of a research program, some of them very extensive. The big industries have proven to themselves that research pays off, and I am sure that it pays off in medicine as well for the benefit of the people of this country; and we have tried to convince this committee with the best evidence we can present to you as to the need of the progress we are making, of the limitation of funds, all data we can think of that will show you how it would save the people of this country money as well as health and happiness; and we have no doubt about it in our minds. I think, I know there are people who are not convinced. I wish I knew how to convince them. I think if we could get them to see some of the people that we see and get close to some of the problems, that they could not help but see them.

Mr. FOGARTY. I agree with you, Doctor, but I think that you will agree that this committee in the past has always looked with favor on these programs, and I think the Congress has generally. When I talk about Members talking against research, I am referring only to a very few; that is not the general view in Congress. I want the record to show that. I am talking mainly about those few individuals who argue against medical-research programs. They are way in the minority, I know. This committee has always been advised of the facts and, as a consequence, has looked with favor on these programs. But the problem is that the other 400-some Members of the House do not have the advantage or the opportunity of listening to you as you tell us of the problems that exist. It is difficult for us in 2 or 3 hours of 1 day to bring out on the floor anywhere near the facts that are presented to this committee. I think that if all the Members of Congress knew the facts as we know them and if they were apprised of the situation as you have apprised us of it, we would be spending 10 times as much as we are at the present time. If all the Members of Congress knew the conditions that exist as far as human beings are concerned, they would not hesitate one minute. But the trouble is that they do not and it is

hard for a subcommittee such as ours to get the full story across. We do not have the time on the floor, and all the Members are not on the floor when we present our side of the story. It is not an easy thing for this committee to get the story across to the Congress or to the people of the country.

But I cannot conceive of anybody—when he sees or hears about these people who are afflicted with these diseases and sees that there is no chance for them, especially when they get something like muscular dystrophy or multiple sclerosis or malignant tumors—who would refuse to acknowledge the need. All that sufferers from such diseases can do is sit and wait until they die; that is a pretty hard thing for anyone to take, I should think. It must be a pretty hard person who could say, "Oh, well, that is going to happen anyway; there is nothing we can do about it, nothing we can do about it." I cannot understand people who think that way.

Dr. SEBRELL. Lou Gehrig comes along. The public gets a great interest. But there must be thousands and thousands just like Lou Gehrig all the time. We do not know what to do for them.

Mr. FOGARTY. Neurological agencies find themselves in a difficult position because they do not have the numbers affected that are affected by heart disease or cancer.

Dr. BAILEY. They do in aggregate.

Mr. FOGARTY. In aggregate, yes; but, as the chairman said awhile ago, it is almost impossible to get a group of people who have an interest in all the neurological diseases together for one purpose. As he mentioned, these voluntary organization are often started and supported by those whose families have been directly affected by one of these diseases. I agree with you that in the aggregate this Institute is one of the most important in the Public Health Service, because these people, I think, have not been given a chance. Their story has not been told.

Dr. BAILEY. The national committee can tell the story in the aggregate.

Mr. HARLOW. The interest of the Public Health Service in this field is indicated by the request we did submit to the Bureau of the Budget for the total funds to be available for this function, which was, relatively speaking, a larger increase than for any of the other items.

Mr. FOGARTY. The trouble has been, too, as I see it, that in the past, as far as the funds for research are concerned, it has always been the Congress that has provided the funds for any advances; the Bureau of the Budget has seldom suggested an increase. It has always been the Congress that has taken the lead in this field. I remember 4 or 5 years ago when the cancer crusade really gained momentum. I remember bills being introduced in the House and the Senate for around $100 million. We knew as a committee that we could not take care of a grant like that; we could not expend that amount of money in a way that would not waste money. That is something we are up against in combating some of those bills that are extreme in the other direction. We have tried in this committee to keep the health-research program on an even keel.

I have talked longer than I anticipated, Mr. Chairman, but when I think of some of the people afflicted with these diseases I just cannot help expressing my feelings. I do not think that we are doing

enough in this field, although I realize that this is a new Institute and that we are just getting it organized and that more will be done in the field in the future.

Mr. FERNANDEZ. My personal observation has been that, when we appropriate money which benefits industry in the pocketbook, nobody complains; but, when we are asked to appropriate funds which benefit mankind and humanity, the tendency is to say, "Let George do it." This is, I believe, the last of the National Institutes, and as they have come up before this committee, one by one, I have noticed that the total requests have not been reduced below what was appropriated last year, but rather that there have been increases. I have noticed that the budget which was filed by President Truman does not reduce them, but rather recommends increases. I do not say that by way of criticism. On the contrary, I thoroughly agree with those recommendations and feel that this is one place where money is not being wasted and one place, or one phase of this vast Government, which should be supported. I noticed in that same budget that the National Science Foundation, which does not come before this committee, received in 1952 an appropriation of $3,500,000, which was increased for this current year to $4,750,000, and the budget carries a recommended appropriation of $15 million. That is an increase of $10,250,000 over and above what was appropriated for the current year. In connection with that, the Bureau of the Budget report says:

> The increase proposed for 1952 is more than offset by reductions in the justifiable requests of other agencies supporting basic research and awarding fellowships, particularly the Department of Defense and the Public Health Service.

I just wondered what they mean by that. Dr. Scheele or Dr. Sebrell would you comment on that?

TRANSFER OF PREDOCTORATE FELLOWSHIP PROGRAM TO NATIONAL SCIENCE FOUNDATION

Dr. SEBRELL. Yes, Mr. Fernandez. What that referred to was the transfer of funds which we had been using to support predoctorate fellows go over to the National Science Foundation and all of the fellowships which we will support from now on will be in postdoctorate fellowships, men who already have their M. D. or doctor of philosophy and who are going into special work in some field of medicine or related to medicine, where they (the National Science Foundation) take over predoctorate fellows in all fields of science. There is no conflict here in these two things. It merely means that where we were supporting predoctorate fellows in the biological and medical sciences, that some of the money will now be diffused over the entire field of science and there will be predoctorate fellows in mathematics and astronomy and archiology and all the various fields of science that will be covered as well as the predoctorates in the biological sciences.

RESEARCH SUPPORT BY NATIONAL SCIENCE FOUNDATION

I should point out that the National Science Foundation does not operate any laboratories or any research of its own. That is purely a supporting foundation. They have no direct research operations of any kind. They are aimed at the basic sciences. It was quite clear

that although one of their divisions is entitled, something like—they have a division of biology—they are set up to work in the basic research field and I know Dr. Waterman quite well. We frequently get together and discuss our programs. He has made it quite clear repeatedly that he has no intention of going into the field of medical research as applied to medicine, and that he has plenty to do in the other fields of science at the present time.

RELATIONSHIP OF INSTITUTE TO NATIONAL SCIENCE FOUNDATION

Mr. FERNANDEZ. The budget report describes it as

* * * basic research in the mathematical, physical, biological, medical, and engineering sciences.

There is no duplication however between work of these institutes and the National Science Foundation?

Dr. SEBRELL. No field where we have to work together but we do work together in this sense, that not so long ago the Surgeon General and staff of NIH appeared before the board of the National Science Foundation, explained to them fully all of our program. We had recently Dr. Waterman and several of his staff out in NIH to explain to our people his intentions and plans and programs, and there is an interagency committee on which we both sit. As I indicated, Dr. Waterman and his top staff are interested, intimately acquainted with the directors of the Institutes and myself and we have frequent personal contact in regard to our programs. There is no duplication in these two programs.

Mr. FERNANDEZ. The National Science Foundation is, of course, a new program and I was wondering if as it develops it might not take over additional functions that you might very well relieve yourself of.

Dr. SEBRELL. The National Science Foundation as I indicated there, is in this field of basic science and it includes all of the fields you mentioned there in which they include basic medical science.

Mr. FERNANDEZ. What is the distinction? I am not so sure that I know.

Dr. SEBRELL. If I may try to explain it as Dr. Waterman interprets it, if I can interpret Dr. Waterman's words, he regards this as the type of research in which the individual is merely seeking knowledge. He has no intention of any application of his knowledge. He is merely seeking something which he can see no possible usefulness out of and where we are directed at finding the cause and the treatment of some disease, everything we do in a sense is practical. We do not want to be doing it if we did not expect it to be some good in the prevention or treatment or cure of or cause of some disease of some kind affecting mankind. They have an advisory and investigative function in the whole, in the entire field of biology and they are, for example, I believe, they are studying and accumulating data on various needs such as what are our scientific manpower resources?

What sort of funds go into all kinds of research from all sorts of sources in this country? I believe right now they are conducting a survey of physiology or physiological research as it is in the United States, which is quite a different thing from where we would be going. Perhaps Dr. Bailey, anything he does in physiology would be directed toward the central nervous system or in the Heart Institute it would be directed toward diseases of the heart and blood vessels.

Mr. FERNANDEZ. That recalls to me the distinction. I had forgotten. That is all I have, Mr. Chairman.

BUDGETARY EFFECT OF TRANSFER OF PREDOCTORATE FELLOWSHIP PROGRAM

Mr. BUSBEY. Dr. Sebrell or Mr. Harlow, why are not the transfers of predoctoral fellowship expenses shown as comparative transfers in your budget?

Mr. HARLOW. I do not know, Mr. Chairman. The way they are shown is as reductions in research fellowships. For example, on page 136, which is the salaries, expenses, and grants of the Heart Institute, the project 1, subproject 2, there shows research fellowships reduced from $450,000 to $357,000; a $93,000 reduction which is the money the Budget took out on account of these fellowships which were to be taken over by the National Science Foundation.

Dr. SHANNON. We do not have the authority to make a transfer. All we have is authority to deduct and hope that the Bureau of the Budget will enter in the National Science Foundation.

Mr. HARLOW. That is not applicable to this situation.

Mr. BUSBEY. In reality, then, it is not an actual reduction; it is a transfer?

Dr. SEBRELL. It shows as a reduction in our budget in the NIH budget. The first day, I believe, I gave you a figure which showed a reduction of——

Dr. SCHEELE. It shows as a $300,000 reduction in the Public Health Service request for research fellowships. In terms of the total appropriation of the executive branch of Government, it shows as a $300,000 increase in Science Foundation requests. In other words, the Government as a whole—there is no change, to Public Health Service, it is $300,000—the National Science Foundation—$300,000 up.

Mr. BUSBEY. This reduction really amounts to $300,000, would you say?

Dr. SCHEELE. Is that correct, Mr. Harlow?

Mr. HARLOW. I am not sure, Doctor. Throughout the whole Institutes, I think it figures about $300,000.

Mr. BUSBEY. Would you supply the exact figure for the record, Mr. Harlow?

Mr. HARLOW. That exact amount is 390,000.

Mr. BUSBEY. I am very happy that Mr. Fogarty expressed the sympathy of this committee in the research program of the National Institutes of Health. I think I could go even a little further than that and say it does not stop at sympathy but I think this committee had a very intense interest in this research program at the National Institutes of Health. While I have not heard anyone say that this money was thrown down a rathole, I am frank to admit that I have on many occasions said that a great many of these billions of dollars that we have spent in programs all over the world have gone down a rathole and I say that from personal investigation on the ground floor in these foreign countries. I am only sorry that some of the $130 billion that we have spent in all these foreign countries on foreign-aid programs since 1940 is not available in the Treasury. If it were we would not be in the financial condition we are today, reaching our national-debt limit of $275 billion. I am sorry that it is not available in the Treas-

ury so we could be more generous in our consideration of these requests for the National Institutes of Health. I say that very sincerely because I think it is a deplorable condition to think that the amount we are spending on these research programs is so small in comparison to what we have spent on some of these Operation Ratholes, as I call them, all over the world. If it had not been for that, I think your road would be much easier in getting even greater consideration than you have from the Appropriations Committee and the Congress as a whole on these research programs.

I am in hope that someday before too long we might be able to have a financial situation in this country where we will not have to look at the budget from the Public Health Service in general as closely as we have had to look at it in the past and I am sure you gentlemen appreciate that we are looking at all budgets rather carefully this year. That is the condition, and while many of my colleagues, obviously the majority of my colleagues, have disagreed with me, I am personally glad to say that I was not a party to bringing about that condition by appropriating billions and billions of dollars for foreign-aid programs.

Mr. FERNANDEZ. I hope that the chairman in describing some of these foreign expenditures as money going down the rathole did not include or does not include in that category the money expended in Mexico for hoof-and-mouth disease because if he does, I thoroughly disagree with him. You mentioned that a while ago.

Mr. BUSBEY. While those funds were spent outside of the United States, I would put it in a special category. That is one program I have to admit I voted for.

WEDNESDAY, APRIL 1, 1953.

CONSTRUCTION OF RESEARCH FACILITIES

WITNESSES

DR. WILLIAM H. SEBRELL, DIRECTOR, NATIONAL INSTITUTES OF HEALTH
ALBERT F. SIEPERT, EXECUTIVE OFFICER, NATIONAL INSTITUTES OF HEALTH
DR. H. VAN ZILE HYDE, CHIEF, DIVISION OF INTERNATIONAL HEALTH
GEORGE PERROTT, CHIEF, DIVISION OF PUBLIC HEALTH METHODS

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$7,035,540		
Contract authorization due to escalation provision	1,398,066	$450,395	
Prior-year balance available:			
Appropriation	7,644,957	12,661,100	$1,436,752
Contract authorization	12,315,672	7,370,605	2,128,494
Total available for obligation	28,394,235	20,491,100	3,565,246
Balance available in subsequent year:			
Appropriation	−12,661,100	−1,436,752	−500,000
Contract authorization	−7,370,605	−2,128,494	−800,000
Obligations incurred	8,362,530	16,925,854	2,265,246

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
1. Design, supervision, etc	$624,649	$550,000	$191,000
2. Construction	6,168,400	8,850,000	2,074,246
3. Purchase and installation of equipment and supplies	1,569,481	7,506,197	
4. Incidental expenses		19,657	
Obligations incurred	8,362,530	16,925,854	2,265,246

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
PUBLIC HEALTH SERVICE			
Total number of permanent positions	28	27	
Average number of all employees	17	14	
Average salaries and grades:			
General schedule grades:			
Average salary	$3,209	$3,230	
Average grade	GS-3.4	GS-3.3	
Crafts, protective, and custodial grades:			
Average salary	$2,819	$2,872	
Average grade	CPC-3.0	CPC-3.0	
01 Personal services:			
Permanent positions	$54,738	$44,790	
Regular pay in excess of 52-week base	329		
Payment above basic rates	143		
Total personal services	55,210	44,790	
03 Transportation of things	1,291	4,500	
06 Printing and reproduction	266	707	
07 Other contractual services	60	19,657	
08 Supplies and materials	429,426	2,110,000	
09 Equipment	1,082,927	5,346,000	
15 Taxes and assessments	301	200	
Obligations incurred	1,569,481	7,525,854	
ALLOCATION TO GENERAL SERVICES ADMINISTRATION			
02 Travel	$1,155	$2,000	$500
04 Communication services	58	100	100
06 Printing and reproduction	23,421	25,000	2,000
07 Other contractual services	590,097	512,900	56,400
08 Supplies and materials	9,918	10,000	1,000
09 Equipment	11,929	4,470,000	345,246
10 Lands and structures	6,156,471	4,380,000	1,860,000
Obligations incurred	6,793,049	9,400,000	2,265,246
SUMMARY			
Total number of permanent positions	28	27	
Average number of all employees	17	14	
Average salaries and grades:			
General schedule grades:			
Average salary	$3,209	$3,230	
Average grade	GS-3.4	GS-3.3	
Crafts, protective, and custodial grades:			
Average salary	$2,819	$2,872	
Average grade	CPC-3.0	CPC-3.0	
01 Personal services:			
Permanent positions	$54,738	$44,790	
Regular pay in excess of 52-week base	329		
Payment above basic rates	143		
Total personal services	55,210	44,790	
02 Travel	1,155	2,000	$500
03 Transportation of things	1,291	4,500	
04 Communication services	58	100	100
06 Printing and reproduction	23,687	25,707	2,000
07 Other contractual services	590,157	532,557	56,400
08 Supplies and materials	439,344	2,120,000	1,000
09 Equipment	1,094,856	9,816,000	345,246
10 Lands and structures	6,156,471	4,380,000	1,860,000
15 Taxes and assessments	301	200	
Obligations incurred	8,362,530	16,925,854	2,265,246

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$5,305,708	$1,945,343	$7,511,197
Obligations incurred during the year	8,362,530	16,925,854	2,265,246
	13,668,238	18,871,197	9,776,443
Deduct:			
Unliquidated obligations, end of year	1,945,343	7,511,197	1,876,443
Obligations transferred to "Construction of research facilities (liquidation of contract authorization), Public Health Service"	10,650,000	3,230,000	3,000,000
Total expenditures	1,072,895	8,130,000	4,900,000
Expenditures are distributed as follows:			
Out of current authorizations	1,072,895	8,130,000	4,900,000
Out of prior authorizations			

Amounts available for liquidation of contract authorization

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$10,650,000	$3,230,000	$3,000,000
Applied to contract authorization	−10,650,000	−3,230,000	−3,000,000
Obligations incurred			

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$12,249,496	$10,280,613	$1,570,444
Obligations transferred from "Construction of research facilities, Public Health Service"	10,650,000	3,230,000	3,000,000
Total	22,899,496	13,510,613	4,570,444
Deduct unliquidated obligations, end of year	10,280,613	1,570,444	
Total expenditures	12,618,883	11,940,169	4,570,444
Expenditures are distributed as follows:			
Out of appropriations to liquidate prior-year contract authorization	12,618,883	1,659,556	3,000,000
Out of prior authorizations		10,280,613	1,570,444

Mr. BUSBEY. The first item under consideration this afternoon is the appropriation request for liquidation of contract authority for construction of the research facilities.

Have you a general statement, Dr. Sebrell?

GENERAL STATEMENT

Dr. SEBRELL. Mr. Chairman, this sum of money is the funds looking toward the completion of construction at Bethesda in connection with the construction of research facilities there.

During the fiscal year 1954 we will complete the expansion of the medical-research facilities authorized under this head at the National Institutes of Health in Bethesda. This project includes the clinical-center building and the auxiliary structures to provide for the utilities, miscellaneous storage, animal breeding, and shop services for the entire National Institutes of Health.

RELATIONSHIP OF 1954 BUDGET ESTIMATE TO TOTAL CONSTRUCTION PROGRAM

The amount requested is $3 million, and that is the liquidating cash divided between stages 1 and 2 of the construction program. You may remember it was authorized in three stages. In this authorization there was provision for so-called escalation. This authority was based on the increase or decrease as the construction-cost index fluctuated after January 1, 1948, so that the rise in construction costs has necessitated this amount of money under that authority in order to get the buildings completed.

Mr. BUSBEY. Is the entire request for 1954 due to the escalator clause in the contract?

Dr. SEBRELL. Yes, sir; it is.

Mr. BUSBEY. What part is this request of the total cost of the clinical center?

Dr. SEBRELL. Stage 1 had a cost limitation on it of $40 million, and today there has been appropriated $39,230,000 of that stage. That is subject to this escalation adjustment I mentioned.

The stage 2 construction has a cost limitation of $8.6 million, also subject to the escalation adjustment, and to date $7.8 million of that has been appropriated.

This sum includes the shops, laundry, storage, and animal buildings. Also, there was a high-voltage electric generator, as Dr. Scheele mentioned, estimated at $800,000, which we have given up, putting that instrument in for high-energy radiation.

Stage 3 construction had a cost limitation of $1,375,000. That includes the housing and grounds and maintenance of buildings. That entire amount has been received and finished.

So, it is only under 1 and 2 items that we are requesting this escalation money.

EFFECT OF EXCLUDING ELECTROSTATIC GENERATOR

Mr. BUSBEY. Will the fact that you are not going to install the high-voltage generator reduce the requirement for the liquidation of the 1954 funds?

Dr. SEBRELL. No; that was not included.

Mr. STEPHENS. In this stage of construction, this electrostatic generator was included as a contract-authority item. The money was not appropriated: it was merely authorized to be put under contract. If it had been appropriated, that $800,000 would have had to be added to the liquidating cash; but, since we have eliminated that contract authority, there will not be a request next year or the next year for money to liquidate.

Mr. BUSBEY. Then it will reduce the contract authority you will use by $800,000?

Mr. STEPHENS. That is right. And that will come up in the next budget, which you will receive shortly—a rescission of that contract authority.

Mr. SIEPERT. But that would not affect the liquidating-cash requirement, since we never made an obligation for that electrostatic generator.

Dr. SEBRELL. This shows up under stage 2, where I indicated there was a cost limitation of $8.6 million, and to date $7.8 million has been

appropriated. That leaves a difference of $800,000 between that and the $8.6 million. So, the stage 2 liquidating cash is entirely an escalation matter.

REVISION OF ORIGINAL ESTIMATE

Mr. BUSBEY. I assume that this $3-million estimate was made last year when you first went before the Bureau of the Budget.

Dr. SEBRELL. Yes, sir; it was made sometime ago.

Mr. BUSBEY. And under the revised budget there is a good chance of its being adjusted?

Dr. SEBRELL. Yes, sir. We estimate now that $2.5 million will probably see this through instead of the $3 million under present conditions. If there is some material change in prices, it would affect that figure.

TRAVEL FUNDS FOR GENERAL SERVICES ADMINISTRATION

Mr. BUSBEY. The budget schedules on page 180 of the committee print show an item of $500 for travel for the General Services Administration. Why will they need that travel money for 1954?

Mr. HARLOW. Those are figures that were submitted by the General Services Administration to the Bureau of the Budget as to how they would spend money that was allocated to them. I confess I do not know what the travel item is, but I am sure it has to do with their supervision of the construction operation which they are carrying on.

Mr. SIEPERT. The General Services Administration, for instance, has a problem now of paying for the travel of inspectors whom they have placed in some of the fabrication plants to be sure the equipment and partitions to complete the clinical center are built according to the specifications and delivered on time.

Mr. BUSBEY. Would that not have been taken care of entirely in the fiscal year 1953?

SCHEDULE FOR DELIVERY AND INSTALLATION OF EQUIPMENT

Mr. SIEPERT. No, sir; because their present delivery schedules for the delivery and installation of the partitions and laboratory equipment will run as far into 1954 as December. In other words, the building is being occupied on a staggered basis. Certain wings will come ahead of others. So, there will be deliveries from these plants until about the middle of fiscal 1954.

Mr. BUSBEY. It seems to me that by July 1 most of this material and equipment will certainly have been fabricated.

Mr. SIEPERT. I do not have their production schedule at the plants, but the schedule on partitions and fixed equipment for their installation is approximately as follows: The clinical-investigation laboratories which are next to the patient area will be ready by June—all of them; the laboratory areas will start to be occupied in June, but the last of them, which will consist of the radiation wing, will not be ready until December. So, there will be deliveries from the plants all through that period of time.

Mr. HARLOW. You are correct, Mr. Chairman, I think, that it will be substantially done, but this schedule does show the equipment purchases in 1954 will amount to almost $350,000.

Mr. BUSBEY. I can appreciate that as far as delivery is concerned, but the actual fabrication of the equipment ought to be practically completed by July 1 of this year.

Mr. SIEPERT. We certainly wish it would.

FUTURE FINANCIAL NEEDS

Mr. BUSBEY. For what will the $1.6 million in contract authority, still to be liquidated after 1954, be used?

Dr. SEBRELL. According to our present calculations, we may not need that money at all. That would be the amount under escalation at the time this estimate was made sometime ago. The amount under escalation was a rough estimate of the amount to get us completely through. As of now, it seems probable that we may not need that at all.

TOTAL ESTIMATED ESCALATION

Mr. SIEPERT. Last spring about this time, when we knew we would have to go into escalation, it was estimated that the total escalation cost of this project would be about $5.5 million before it was finished. There was a finding at the time that there was a 21-percent increase in the level of construction costs. In April 1952, the Surgeon General sent a letter to the chairman of this subcommittee, as well as of the Senate subcommittee, indicating what the problem was and that we would have to come in for escalation in 1954. As of today, the total estimated escalation is $4,011,000.

Now, the reason for this $1.6 million is that at the time this budget was prepared we thought our total escalation would be the $3 million requested plus $1.6 million in 1955. I hope we are not being optimistic, but we think we will be able to complete the building with the escalation requested in 1954; if so, this $1.6 million would not be needed.

APPROPRIATION LANGUAGE CONCERNING UNEXPENDED BALANCES

Mr. BUSBEY. I notice in the appropriation language, on page 178 of the committee print, that you are requesting the language "to remain available until expended." What is your reason for desiring that language?

Mr. HARLOW. Mr. Chairman, the usual type of language for construction projects, since they do run over a period of years, is that the money be appropriated and remain available until expended. As a matter of fact, we have had several appropriations, an appropriation in each act, ever since this construction was started, all of which money has been available until expended. And the continuation of that language in this bill will enable us to merge that with any funds which have heretofore been appropriated and apply those to the payment of these bills as they come in.

Mr. BUSBEY. In your budget schedule of expenditures, on page 181 of the committee print, you show that all of the $3 million you are requesting will be expended in 1954.

Mr. HARLOW. Yes, sir; we are showing that the $3 million will be expended plus $1,570,000, which will carry over from the previous

appropriations. That may not turn out, however, very well; we may still have some cats and dogs left over that are unpaid at the end of 1954 that we will need to take care of.

Mr. STEPHENS. Let me say this about that language. That language could not be construed, I do not think, so that the money could possibly be used for anything other than what it was appropriated for. In other words, if it happened to be left, it would not be used for something else.

Mr. BUSBEY. But it is still true, is it not, that if this amount should turn out to be more than you actually need, it would remain on the books forever?

Mr. STEPHENS. Yes, sir; as long as it was not rescinded. If they would use out of that money all but $100,000, it would remain available until it was rescinded.

Mr. BUSBEY. Would it not be simpler to carry it for fiscal year 1954 and then, if you should run into difficulty, get an appropriation for 1955, rather than carrying it on the books indefinitely as unexpended, which could easily happen under this language?

Mr. STEPHENS. What would happen there is if we were not to get all of the bills in and paid in 1954 and there were some of those so-called cats and dogs, we would not know that until we were already before you with the 1955 estimates. In 1955, we would have to present you with that item for some small carryover. The difficulty is that we will be considering the 1955 budget estimates in the next 90 days. We won't know in the next 90 days what amount of the bills will be paid in 1954. If we are restricted to 1 fiscal year, it may well mean the processing of a small supplemental; even though we used 90 percent of the total. If the balance lapsed because of the end of the fiscal year, we would have to come back for other money.

Mr. HARLOW. I do not think that would be quite correct, because even the 1954 appropriations stay on the books for 2 years.

Mr. STEPHENS. If they are obligated.

Mr. HARLOW. Yes; if they are obligated for that purpose. We could work the thing out as you suggest, Mr. Chairman, but we would need also to include some language which would bring in previous amounts appropriated so that we would still have the one fund out of which to pay. In other words, we do not want to set up a separate $3 million appropriation and also have to account separately for the $1.5 million that is going to be still available in 1954 out of previous appropriations.

Mr. BUSBEY. At this stage of construction, I do not look favorably on what might be termed "an open-end appropriation." Why not include a provision limiting the carryover of funds either to the end of fiscal year 1954 or of fiscal year 1955?

Mr. HARLOW. I think 1955 would certainly get it all.

SERVICE AND SUPPLY FUND

WITNESS

ROY L. HARLOW, CHIEF FINANCE OFFICER, PUBLIC HEALTH SERVICE

Amounts available for obligation

Appropriation or estimate (obligations incurred)—1954 ..... $200,000

Analysis of expenditures

Obligations incurred during the year (total expenditures out of current authorizations—investment in the revolving fund)—1954 ..... $200,000

A. Statement of sources and application of funds

[For fiscal years ending June 30, 1952, 1953, and 1954]

	1952 actual	1953 estimate	1954 estimate
FUNDS APPLIED			
To Operations			
Supply depot activities:			
Acquisition of assets	$6,320	$3,345	$1,000
Expenses:			
Purchases	925,572	883,452	884,000
Other expenses	138,356	140,000	140,000
Adjustment of prior year's expenses	1,148		
Total expenses	1,065,076	1,023,452	1,024,000
Total funds applied to operations, supply depot activities	1,071,396	1,026,797	1,025,000
National Institutes of Health activities:			
Expenses:			
Purchases			1,035,000
Other expenses			127,500
Total funds applied to National Institutes of Health activities			1,162,500
Increase in selected working capital items		1,471	120,000
Total funds applied to operations	1,071,396	1,028,268	2,307,500
To Financing			
Increase in Treasury cash	59,346	1,732	90,000
Total funds applied	1,130,742	1,030,000	2,397,500
FUNDS PROVIDED			
By Operations			
Supply depot activities: Income:			
Sales	1,045,984	1,015,000	1,015,000
Other income	17,680	15,000	15,000
Total funds provided by income	1,063,664	1,030,000	1,030,000
National Institutes of Health activities:			
Income: Sales			1,167,500
Total funds provided by income	1,063,664	1,030,000	2,197,500
Decrease in selected working capital items	67,078		
Total funds provided by operations	1,130,742	1,030,000	2,197,500
By Financing			
Appropriation			200,000
Total funds provided	1,130,742	1,030,000	2,397,500
EFFECT ON BUDGETARY EXPENDITURES			
Total funds applied to operations	1,071,396	1,028,268	2,307,500
Total funds provided by operations	1,130,742	1,030,000	2,197,500
Net effect on budgetary expenditures	−59,346	−1,732	110,000
The above amounts are charged (or credited (−)) as follows:			
To budgetary authorizations			200,000
To net receipts of enterprise	−59,346	−1,732	−90,000

B. Statement of income and expense

[For fiscal years ending June 30, 1952, 1953, and 1954]

	1952 actual	1953 estimate	1954 estimate
SUPPLY DEPOT ACTIVITIES			
Income:			
Sales	$1,045,984	$1,015,000	$1,015,000
Other income	17,680	15,000	15,000
Total income	1,063,664	1,030,000	1,030,000
Expenses:			
Cost of goods sold:			
Purchase of supplies and materials	925,572	883,452	884,000
Donated supplies and materials	8,440		
Supplies and materials available for sale	934,012	883,452	884,000
Increase (−) or decrease in inventory	−5,460	3,586	3,000
Total cost of goods sold	928,552	887,038	887,000
Other expense	138,356	140,000	140,000
Subtotal	1,066,908	1,027,038	1,027,000
Depreciation	2,280	2,600	2,600
Total expenses	1,069,188	1,029,638	1,029,600
Net income (or loss (−)) from supply depot activities	−5,524	362	400
NATIONAL INSTITUTES OF HEALTH ACTIVITIES			
Income: Sales			1,167,500
Expenses:			
Cost of goods sold:			
Purchases of supplies and materials			1,035,000
Donated supplies and material			1,000,000
Supplies and material available for sale			2,035,000
Increase (−) in inventory			−1,000,000
Total cost of goods sold			1,035,000
Other expenses			127,500
Subtotal			1,162,500
Depreciation			5,000
Total expenses			1,167,500
Net income from National Institutes of Health Activities			
Net income (or loss (−)) for the year	−5,524	362	400
Retained earnings, beginning of year	41,326	34,654	35,016
Adjustment applicable to prior year expense	−1,148		
Retained earnings, end of year	34,654	35,016	35,416

C. *Statement of financial condition*

[As of June 30, 1952, 1953, and 1954]

	1952 actual	1953 estimate	1954 estimate
ASSETS			
Current assets:			
Cash with U. S. Treasury	$243,268	$245,000	$335,000
Postage stamps	51		
Accounts receivable	192,085	195,000	362,000
Inventories	631,586	628,000	1,625,000
Stores	3,950	4,000	5,000
Prepaid expenses	158		
Total current assets	1,071,098	1,072,000	2,327,000
Fixed assets:			
Equipment	51,655	55,000	181,000
Less portion charged off as depreciation	22,058	24,658	57,258
Total fixed assets	29,597	30,342	123,742
Total assets	1,100,695	1,102,342	2,450,742
LIABILITIES			
Current liabilities: Accounts payable [1]	108,715	110,000	158,000
INVESTMENT OF U. S. GOVERNMENT			
Principal of fund:			
Appropriation	250,000	250,000	450,000
Donated assets, net	707,326	707,326	1,807,326
Total principal	957,326	957,326	2,257,326
Retained earnings	34,654	35,016	35,416
Total investment of U. S. Government	991,980	992,342	2,292,742
Total liabilities and investment of U. S. Government	1,100,695	1,102,342	2,450,742

[1] Excludes obligations outstanding for items on order of: $296,942 as of June 30, 1952, $107,602 as of June 30, 1953, and $178,325 as of June 30, 1954.

SCHEDULE A–1.—*Accrued expenditures by objects*

Object classification	1952 actual	1953 estimate	1954 estimate
Supply Depot Activities			
Total number of permanent positions	28	24	24
Average number of all employees	23	24	24
Average salaries and grades:			
General schedule grades:			
Average salary	$3,407	$3,491	$3,570
Average grade	GS–4.0	GS–4.0	GS–4.0
Crafts, protective, and custodial grades:			
Average salary	$2,846	$2,948	$3,006
Average grade	CPC–3.1	CPC–3.8	CPC–3.8
01 Personal services:			
Permanent positions	$82,230	$90,780	$92,355
Regular pay in excess of 52-week base	231	237	243
Total personal services	82,461	91,017	92,598
02 Travel	657	500	500
03 Transportation of things	29,021	30,000	30,000
04 Communication services	13,857	13,500	13,500
05 Rents and utility services	6,652	7,000	7,000
06 Printing and reproduction	49,644	50,000	50,000
07 Other contractual services	72,187	65,000	65,000
08 Supplies and materials	901,941	565,315	744,000
09 Equipment	15,400	15,000	15,000
15 Taxes and assessments	124	125	125
Total obligations	1,171,944	837,457	1,017,723
Add (or deduct (−)) the net changes in items on order	−100,548	189,340	7,277
Total accrued expenditures, supply depot activities	1,071,396	1,026,797	1,025,000

SCHEDULE A–1.—*Accrued expenditures by objects*—Continued

Object classification	1952 actual	1953 estimate	1954 estimate
National Institutes of Health Activities			
Total number of permanent positions			36
Average number of all employees			33
Average salaries and grades:			
General schedule grades:			
Average salary			$3,605
Average grade			GS–4.5
Crafts, protective, and custodial grades:			
Average salary			$2,648
Average grade			CPC–3.0
01 Personal services:			
Permanent positions			$114,525
Regular pay in excess of 52-week base			475
Total personal services			115,000
02 Travel			100
03 Transportation of things			900
04 Communication services			1,500
06 Printing and reproduction			2,000
07 Other contractual services			2,800
08 Supplies and materials			1,118,000
15 Taxes and assessments			200
Total obligations			1,240,500
Deduct net change in items on order			78,000
Total accrued expenditures, National Institutes of Health activities			1,162,500
Total accrued expenditures	$1,071,396	$1,626,797	$2,187,500

Mr. BUSBEY. The next item is the appropriation request for fiscal year 1954 for "Service and supply fund." Mr. Harlow, I believe you have a short statement to present to the committee.

GENERAL STATEMENT

Mr. HARLOW. Yes, Mr. Chairman.

Mr. Chairman and members of the committee; the service and supply fund was established by act of July 3, 1945, with an initial appropriation of $250,000 for the purpose of operating a central supply service for the Public Health Service and other Government offices, and such other services as the Surgeon General, with the approval of the Administrator of the Federal Security Agency, determines may be performed more advantageously as central services. The fund is reimbursed from applicable appropriations and funds on the basis of rates which include charges for personal services, materials, depreciation, and other expenses.

Operations financed by the fund include (1) purchase, storage, and issue of medical supplies, forms, and stationery items; (2) a central point for temporary storage of bulk materials; (3) pharmaceutical laboratory services, resulting in a considerable saving under prices from outside sources; (4) a testing laboratory which assures requisitioning units of high quality at a minimum cost; and (5) a small motorpool.

Up to the present time the fund has been used for operation of the supply depot at Perry Point, Md. During 1954 it is proposed to bring under this fund similar operations at Bethesda, Md., serving the National Institutes of Health. This decision was reached after a

survey of the problem by an interdepartmental group including representatives of the General Accounting Office, the General Services Administration, and the Federal Security Agency. The proposal was recommended unanimously by the committee. At first the fund will be used to finance only central-stores operations at Bethesda, but eventually its use will be extended to such other activities as may be advantageously financed in this manner. The $200,000 appropriation requested in the 1954 budget is the minimum additional working capital required to finance operations at Bethesda.

RECOMMENDATIONS OF INTERDEPARTMENTAL SURVEY COMMITTEE

Since I have mentioned this survey group which has been with us on this problem, I should like, if I may, to quote some excerpts from their report in which they deal quite generally with property accounting at the National Institutes of Health. They say:

> Perhaps the most significant of the recommendations included in this report is that which proposes the establishment of a central-stores revolving-fund operation. This type of financing is particularly appropriate at the National Institutes of Health, due to the scope of the stores operation, and because of the multiple activities, financed from several different appropriations, served by the supply warehouse. In addition, it is felt that the operation of this activity on a self-supporting basis, utilizing appropriate commercial-type methods, will result in a more efficient and economical operation, susceptible to effective financial control and audit. In this connection, the working group recommends the maintenance of revolving-fund branch-office general-ledger accounts at the National Institutes of Health.

PRESENT STOCKING OPERATIONS

Then, as a background for some of their recommendations, they make this statement. I quote:

> The central-stores activity (including substorerooms) stocks and issues a wide variety of research, operating, and administrative supplies and equipment to the several institutes, which are financed from separate appropriations. At the time of the survey, there were approximately 4,000 different items in stock with an aggregate value of $500,000. With the opening of the clinical center, it is expected that the number of different stock items will gradually increase to approximately 10,000; the value of issues during the fiscal year 1954 will aggregate $1,250,000, and line items of issues will amount to some 8,000 to 12,000 per month.
>
> At present, stock replenishments are charged to the appropriations of the several "customer" institutes at the time of purchase. Consequently, stores issues are not charged to appropriations at the time of issue. At the beginning of each month (or longer period) an allotment is set up under each appropriation. These allotments are used for the purchase of central-stores items. These allotments are based on the estimated withdrawals from stock for the current month (or period) adjusted for the difference between the previous month's (or period's) allotments and the actual withdrawals. At the time stock is purchased, the eventual "customer" institute (or institutes) is not known. Stock purchases are financed by charging the various appropriations "in rotation" until each allotment is substantially or completely exhausted. This procedure results in the reporting of expenditures by each appropriation which, although in approximately the correct dollar amount (on a cumulative basis), have little relationship to the specific supplies and equipment actually used by the appropriations or programs.

From this last quotation I have read, which describes our present operation of the stock out there, you can readily see that we have a somewhat complicated operation which this working capital fund would greatly simplify. And I should like also to say that in some of the preliminary reports, which did not become a part of their final report, the task group or working committee pointed out some of the advantages of this type of operation, particularly advantages over trying to operate as we have been operating.

ADVANTAGES OF FINANCING BY WORKING CAPITAL FUND

In the first place, it provides a single means for consolidated financing and accounting for the acquisition and holding of stocks of common items of materials, supplies, and equipment, the costs of which are chargeable, when issued for use, to allotments or other accounts identified with more than one appropriation or fund. It provides currently and continuously cash for replenishments of stocks. This assumes, of course, that adequate start-off cash is available when we obtain it.

There is some reason to believe that this sort of operation may be a deterrent, and certainly will be no incentive, to purchasing materials other than those normally required, particularly in those situations that we have heard mentioned about using up June balances, where you perhaps have heard of some of those things.

Furthermore, purchases of stock items may be timed to take advantage of favorable prices, and such timing may be impossible if the items were financed under limitations of annual appropriations and related quarterly apportionments.

Then the use of the revolving fund can be a force for close control over stocks carried in the fund through the control over financial resources of the fund in relation to supply requirements.

There are some others I could mention, but I think I have said enough to indicate the importance that this task force placed on this item and with which we are in thorough agreement.

I might say the calculations of the task force resulted in a recommendation that we come to you with a request for $412,000. However, the item you see before you is for $200,000, and we would like to make an attempt to get the operation under way with that fund.

Incidentally, I might also add that the appropriation of this particular amount of money results in no actual expenditures from the Treasury; it is merely, as it is said to be, a revolving fund where we make the initial purchases and then we get the reimbursement when the stock is issued.

Mr. BUSBEY. Will you merge the $200,000 with the other fund that has been set up for the central purchasing of equipment and supplies for the Public Health Service, or is this going to be used as a special revolving fund for the National Institutes of Health?

Mr. HARLOW. As far as the Treasury is concerned, it will all be one fund. However, through the allocation process in the Surgeon General's Office, this money will actually be allocated to the NIH operation.

DECENTRALIZATION OF PURCHASING AUTHORITY

Mr. BUSBEY. Explain to the committee briefly, if you will, the necessity of having a central purchasing agent in the Public Health Service.

Mr. HARLOW. We do not have a central purchasing agent in the Public Health Service. We have decentralized the purchasing authority to the larger stations, and among those will be the National Institutes of Health.

SUPPLY STATION AT PERRY POINT, MD.

We do operate at Perry Point, Md., a supply station where we do central purchasing, where we stock central supplies which are purchased and which are issued to our various stations on requisition. That has many advantages; where we have common items, as we do in all hospitals, of course, we can take advantage of better prices. We calculated at one time that the operation had saved us well over $1 million in the purchase of penicillin alone, because we were able to purchase large quantities and really get the manufacturers interested in giving a price.

Mr. BUSBEY. How about the items you stock at Perry Point, Md., that could be purchased through GSA?

Mr. HARLOW. We do not stock anything at Perry Point unless we can beat GSA prices.

Mr. BUSBEY. Why would you be able to beat GSA prices on such items as alcohol, absorbent cotton, cotton flannel, glassware, microscopes, blankets, clothing, pillows and sheets, silverware, towels, thermometers, and so forth?

Mr. HARLOW. It depends on when you hit the market. GSA contracts, for the most part, are annual contracts. Bidders are faced with the necessity of anticipating what the markets will be, what the costs will be, over the period of a year. We rarely make annual contracts for a supply. We buy in bulk. It is all delivered at one time, and the man knows almost to a dollar what the costs are when he bids.

Mr. BUSBEY. Would it not be possible for other agencies of the Government to do the same thing you are doing at Perry Point—take advantage of the markets?

Mr. HARLOW. Many of them do. There are such things as mandatory items which are required to be purchased through General Services' operations. On those, of course, unless we can get a waiver from General Services, we have to deal with their contractors. I understand the Veterans' Administration does have extensive purchasing outside the General Services run of contracts.

Mr. BUSBEY. I wonder sometimes why we have GSA, the way things are operated.

Mr. HARLOW. I do not know that I can satisfy your doubts, Mr. Chairman, but they do have a tremendous operation and in many, many items save the Government thousands of dollars. Besides, they have functions other than purchasing; they have contracting.

Mr. BUSBEY. I cannot help thinking of a very sore spot with me in regard to the quality of the products in supply at the stationery store for Members of Congress. Frankly, I think we are paying far too much for the quality we get. For the same price, you can go to the retail stores and buy things of a much better quality. That applies whether it is Scotch tape or second sheets for writing letters or many other items.

If you can buy more cheaply, it seems to me that other agencies of the Government could buy more cheaply, too. It may be that we are buying too much through GSA.

Mr. HARLOW. I should have said that we rarely ship stuff west of the Mississippi from the supply depot at Perry Point, because the cost of transportation then begins to run the prices up too much

and, in those areas where we have GSA warehouses, we do use them extensively. I think, for example, the bulk of the supplies which go into the Lexington Hospital come through GSA either from Louisville or Cincinnati.

TESTING LABORATORY AT PERRY POINT

Mr. BUSBEY. Now tell the committee about the testing laboratory that has been established at Perry Point.

Mr. HARLOW. I am afraid I will not be able to say a great deal about that, except in somewhat general terms.

For a long time we have run into problems in connection with items which have been stocked at Perry Point which, when put into the hands of our operating people in the hospitals, have not been found to act as perhaps they should. As a result of that, we have been casting about for some way of getting this testing done. We took up this question of testing a year ago or more with the Baltimore laboratory of the Federal Food and Drug Administration, which is a part of the Federal Security Agency. We found they were equipped to test some of the things we wanted tested but not by any means all of them. Furthermore, there would be a question of priority involved, in which their work would have to take precedence, and we might—and certainly would occasionally—run into some delays in getting work done that they could do.

On the basis of the time required to conduct these tests, I believe it was figured out it would cost us about $25 on the average to get the testing done at the Food and Drug laboratory. Then, quite recently, as a result of a report that we had that this committee was also interested in this thing, we again took it up not only with the Baltimore laboratory but with officials of the Federal Food and Drug Administration in Washington, and there was—I did not participate in the negotiations—an agreement on the part of the Food and Drug Administration, in the first place, that they could not do all of it at Baltimore and, in the second place, that the way we were doing it was about as economical a way to do it as we could expect to get it done under any circumstances, either by contracts with private laboratories or any other method that might be approached.

Mr. BUSBEY. When was this testing laboratory at Perry Point opened?

Mr. HARLOW. I think it has been in operation perhaps for a little less than a year. We have always had a pharmacist in charge there, and he has done a little testing all through the years, but the setting up of equipment to do the complete job I think has only been done in the last year.

ITEMS TESTED

Mr. BUSBEY. Just what testing do you do at Perry Point?

Mr. HARLOW. We test drugs, chemicals, and most all types of powders and liquids and things of that sort, together with some other articles. I do not have the list, but will be glad to supply it.

Mr. BUSBEY. I would appreciate it if you would supply it for the record.

Mr. HARLOW. Yes, sir.

(The information is as follows:)

LIST, BY CATEGORY, OF ITEMS SUBJECT TO TEST

Chemicals
Pharmaceutical preparations
Adhesive plaster
Bandages
Surgical instruments
Hypodermic needles and syringes
Laboratory glassware
Dental instruments and supplies
Hospital garments
Textiles
Hospital utensils

Mr. BUSBEY. It seems to me that most of the articles you test, without having the benefit of the list before me, come in a category that Food and Drug could take care of just as well.

Mr. HARLOW. I am sure when you get the list you will see there are many items on there that would not come under the purview of the Food and Drug Administration.

Mr. BUSBEY. What other items come to your mind that would be tested at Perry Point?

Mr. HARLOW. I just cannot think of any at the moment.

REJECTION OF MATERIALS

Mr. BUSBEY. Now, suppose that in testing these different articles at Perry Point, you find that the merchandise purchased is inferior or does not come up to specifications. What happens then?

Mr. HARLOW. The shipment is rejected and goes back to the purveyor.

Mr. BUSBEY. Do you have to inspect and test everything that comes in?

Mr. HARLOW. We normally, of course, inspect every shipment, but not every shipment, of course, would be tested. Inspection would include the quantities, for one thing.

Mr. BUSBEY. Have you ever had to sue a supplier for the delivery of inferior merchandise?

Mr. HARLOW. No, sir; we have never done that. Where our main trouble has been along that line has been in years past when it was hard to get deliveries and we have had to buy from another source against a contractor who failed to make delivery.

Mr. BUSBEY. How much of the material purchased at Perry Point is rejected?

Mr. HARLOW. May I supply that?

Mr. BUSBEY. Surely.

(The information is as follows:)

Since the testing laboratory was not completed until January of this year, there is little experience to report thus far. In the past, some purchases have been rejected, but the normal practice is to allow the vendor an opportunity to replace his first shipment with acceptable goods. This has reduced the number of outright rejections to very few. The establishment of the laboratory will not necessarily result in a large increase in rejections because the laboratory continually initiates improvements in purchase specifications, also the requirement that all items will be subject to test is now a condition in bid invitations. These factors tend to eliminate the less reliable vendors from bidding.

Very little of the material purchased for Perry Point has been rejected outright. During the past year nine items were rejected on the initial shipment. In every instance the vendor made replacements with supplies that met specifications. While this involves some delay, it is usually more to the interest of the Govern-

ment than invoking a formal declaration of default of contract and debarment of the contractor from the bidders list (blacklisting).

Mr. STEPHENS. There is one item of information you might be interested in. Where a buyer on one or more occasions fails to meet specifications, he can, through the process of publication, be put on what is called the blacklist where he is not eligible to bid any more for a certain number of years. You might see this list published occasionally. Treasury Procurement used it. And General Services would say that a vendor or contractor who got on the so-called blacklist could not bid. That is the general sanction against that.

Mr. BUSBEY. Have you ever put anybody on the blacklist because his goods have been inferior?

Mr. STEPHENS. I do not know if Perry Point has. I have read the lists of those people.

Mr. BUSBEY. Of course, we are only interested in Perry Point in this appropriation request.

Mr. STEPHENS. I do not know whether they have ever blacklisted anybody or not.

Mr. BUSBEY. What has been the record on that?

Mr. HARLOW. I do not know positively. My impression is we have never had to go that far. Of course, these things do happen, which have happened with us, that the contractor, you might say, after he has been in trouble over these items, very frequently will not bid on the next request that goes out. I think it is more a process of self-elimination than it is compulsory elimination by these fellows dropping out of the market as far as Government business is concerned.

Mr. BUSBEY. It seems to me that either there have been no serious violations of contract specifications, or else the Public Health Service has been remiss in its duty to prosecute if there has been anything substantially wrong with those materials.

Mr. HARLOW. We are so constituted, perhaps unfortunately, that we like to negotiate rather than litigate.

AUTHORITY FOR ESTABLISHING LABORATORY AT PERRY POINT

Mr. BUSBEY. Was there ever any mention to this committee at any time that you were going to deviate from the established operation to the extent of establishing a completely new laboratory?

Mr. HARLOW. If that be considered a deviation, no; but we consider it a normal part of the supply operation and that the thing should have been done all these years.

Mr. BUSBEY. There certainly was no mention of a laboratory when we held hearings on the creation of this appropriation.

Mr. HARLOW. I am sure there was not. On the other hand, I am also sure we did not go so far as to indicate we would not test the stuff delivered to us to the extent of our ability in order to be sure the articles met specifications.

Mr. BUSBEY. I noticed in your general statement, in the first paragraph, that you quoted what appears to have been taken from the law; that the purpose of the appropriation was for the operating of a central supply service for the Public Health Service and other Government offices and such other services as the Surgeon General, with the approval of the Administrator of the Federal Security Agency, determines may be performed far more advantageously as central ser-

vices. I assume that this laboratory would come under that definition. Has the Surgeon General or the Administrator of the Federal Security Agency evidenced his approval of setting up this laboratory?

Mr. HARLOW. I do not think that was submitted to the Administrator. It was regarded as a part of the supply operation.

Mr. BUSBEY. Who made the determination, then, to set up this laboratory?

Mr. HARLOW. I think that was done under the supervision of the officer in charge of our general administrative services who is responsible for the operation of the Perry Point supply depot.

Mr. BUSBEY. Who is that?

Mr. HARLOW. His name is Brunson. It was either he or his predecessor. I think he was in charge when this was done.

Mr. BUSBEY. What is Brunson's title?

Mr. HARLOW. He is Chief of the Division of General Services in the Office of the Surgeon General.

Mr. BUSBEY. And he has been in that position how long? Was he there before it was decided to establish this laboratory?

Mr. HARLOW. I am almost certain he was.

Mr. BUSBEY. Then he would be the one who would have issued a directive to establish this laboratory?

Mr. HARLOW. Yes, sir.

Mr. BUSBEY. Would it be possible for you to get a copy of that so-called directive and supply it for the record?

Mr. HARLOW. Yes, sir. I am sure it is available.

Mr. BUSBEY. I would appreciate it if you would.

(The committee was subsequently advised that no formal document was issued.)

Mr. BUSBEY. You believe that he would have the authority, without the approval of anyone else, to give the order to go ahead with this project?

Mr. HARLOW. Yes, sir. I quite sincerely think this is a part of the supply depot operation.

Mr. BUSBEY. And neither the Surgeon General nor the Administrator of FSA gave any approval, nor was it necessary?

Mr. HARLOW. I do not think there was such approval. There possibly may have been. I do not think it was necessary, however.

Mr. BUSBEY. I am going to read into the record at this point the part of the act dealing with the service and supply fund for which you are asking this appropriation:

> For the establishment of a service and supply fund, $250,000, without fiscal year limitation, for the payment of salaries, travel, and other expenses necessary to the maintenance and operation of (1) a supply service for the purchase, storage, handling, issuance, packing, or shipping of stationery, supplies, materials, equipment, and blank forms, for which stocks may be maintained to meet, in whole or in part, requirements of the Public Health Service and requisitions of other Government offices, and (2) such other services as the Surgeon General, with the approval of the Administrator of the Federal Security Agency, determines may be performed more advantageously as central services * * *

It seems to me that that language is rather explicit and that the approval of the Administrator of the Federal Security Agency and of the Surgeon General certainly should have been obtained before the establishment of this testing laboratory.

Do you care to comment on that?

Mr. HARLOW. My reasoning in thinking otherwise runs along this line: Had we submitted samples of shipments to the Food and Drug laboratory or to some commercial laboratory for analysis and testing, that, it seems to me, would certainly not have required any approval on the part of the Surgeon General. It is the normal thing that people purchasing large quantities of these things, particularly drugs, would do. It would become an expense of the maintenance of the supply depot, and those expenses would have gone into the operating expenses of the depot. They would have been assimilated in the cost of the things that were issued, and thereby the expense of testing would have been recaptured to the supply fund. I see no difference between that and doing the testing with our own people.

Mr. BUSBEY. Have you had much testing done by commercial laboratories?

Mr. HARLOW. I do not think we have ever done a great deal of it. We have for years had thermometers tested by the Bureau of Standards.

PERSONNEL AT PERRY POINT STATION

Mr. BUSBEY. How many people are employed in this testing laboratory?

Mr. HARLOW. I do not have it separated as to the laboratory services. I believe the entire operation at Perry Point has 24 positions.

Mr. BUSBEY. Where are those positions carried in the justifications?

Mr. HARLOW. They show up on page 191 of the committee print. I do not know that they are set forth separately in the justifications. The only thing in the justifications, as I understand, relates to the $200,000 we are requesting for the NIH operation.

PURCHASE AND INSTALLATION OF EQUIPMENT FOR LABORATORY

Mr. BUSBEY. Mr. Harlow, would you submit for the record a list of the equipment purchased for this laboratory, its cost, and the amount spent for materials and labor in installing it?

Mr. HARLOW. Yes, sir.

Mr. BUSBEY. And, if the Veterans' Administration bore any part of its cost, include that cost in the statement.

Mr. HARLOW. Yes, sir. I doubt very much, however, if they did; but we will ascertain that.

(The information requested is as follows:)

Equipment purchased:	Costs
Furnace, muffle	$163.00
Rheostat for furnace	85.00
Filter, Seitz	17.45
Melting point app	67.00
Balance, anal., Becker ABZ	449.00
Spectrophotometer, D. U	1,250.00
Electrode, Calonel, 30-inch	8.50
Electrode, glass, 30-inch	11.00
Electrode, pt., for model G	5.50
Flexaframe, Set No. 3	33.00
Desiccator and cover	50.40
Plates, desiccator, s feet	11.02
Plates, desiccator, c feet	9.96
Extractor, Soxhlet	33.28
Counter, Colony, Quebec	71.00
Water bath, cylindrical	77.00
Watch, stop, 7-jewel	9.05
Tablet disint. apparatus	140.00
Stool, lab., utility	15.00
Refractometer, Fisher	120.00
Gyrosolver, 115-volt	135.00
Battery, storage, wet	33.20
Centrifuge, clinical	95.00
Centrifuge, heap, 4-place	15.10
Microscope, binocular	487.45
Heater, Glas-Col, mantle	12.75
Support, heating mantle	3.27
Clock, interval timer	8.92
Illuminator balance	16.00
Box, sterilizing, Petri dish	21.00
Box, sterilizing, Pipette	14.40
Power-supply s battery	142.50
Ultraviolet accessory attachment	300.00
Rheostat (Powerstat)	23.00
Stirring app. Mag-Mix	32.50
Weights, anal. class S	46.80
Beckman pH Model G	220.50
Pump vacuum cenco HY-VAC	81.90
Oven, isotemp, Fisher	112.50
Support, Burette, c base	17.00
Balance illuminator cantilever	45.00
Cork-borer set	6.00
Buffer set (pH2-10)	5.00
Micrometer, caliper	8.50
Vernier, caliper	7.50
Stands, support, apparatus	5.00
Stands, support, app, X-LGE	8.00
Tripod, iron	4.00
Distilling app. Kjeldahl	97.00
Digestion app. Kjeldahl	105.00
Total	4,736.43
Material (for building alteration)	807.13
Labor [1] (contracted for)	199.75
Total	5,743.31

[1] Subsequently all of the labor was provided by the depot's maintenance force at no extra expenditure

NOTE.—The Veterans' Administration did not bear any part of the cost.

FRIDAY, FEBRUARY 27, 1953.

RETIRED PAY OF COMMISSIONED OFFICERS

WITNESSES

ROY L. HARLOW, CHIEF FINANCE OFFICER
DR. ERWIN C. DRESCHER, MEDICAL DIRECTOR, CHIEF OF DIVISION OF COMMISSIONED OFFICERS

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate		$1,186,000	$1,215,000
Prior year balance available			53,000
Total available for obligation		1,186,000	1,268,000
Balance available in subsequent year		−53,000	
Obligations incurred		1,133,000	1,268,000
Comparative transfer from "Commissioned officers, pay, and so forth, Public Health Service"	$1,019,075		
Total obligations	1,019,075	1,133,000	1,268,000

Obligations by activities

Retired pay of commissioned officers:	
1952	$1,019,075
1953	1,133,000
1954	1,268,000

Obligations by objects

12 Pensions, annuities, and insurance claims:	
1952	$1,019,075
1953	1,133,000
1954	1,268,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Obligations incurred during the year (total expenditures)		$1,133,000	$1,268,000
Expenditures are distributed as follows:			
Out of current authorizations		1,133,000	1,215,000
Out of prior authorizations			53,000

Mr. BUSBEY. The committee will come to order.

The first matter under consideration is the estimate for retired pay of commissioned officers. We will hear Mr. Harlow, Chief Finance Officer of the Public Health Service.

GENERAL STATEMENT

Mr. HARLOW. Mr. Chairman and members of the committee:

This is an estimate for retired pay of commissioned officers of the Public Health Service. The commissioned corps of the Public Health Service is a group corresponding to the commissioned corps of the Army, and its members receive the same pay and allowances as officers in corresponding grades in the Army. The lowest grade is that of

a junior assistant, which corresponds to second lieutenant in the Army, and the highest is that of the Surgeon General, which corresponds to that of major general in the Army.

Although active-duty pay and allowances of our officers are the same as for the Army, the retired pay is governed by retirement provisions of the Public Health Service Act. Officers are retired for age, disability, or after specified periods of service in accordance with provisions of law.

As of December 31, 1952, there were 225 officers on the retired list. It is estimated that by June 30, 1953, an additional 13 will be retired, making the total 238 at the beginning of fiscal year 1954.

1954 BUDGET ESTIMATE

Based on past experience and records of those eligible for retirement, it is estimated that 23 officers will retire during fiscal year 1954—14 for disability, 2 for age, and 7 for service. Four deaths have been estimated for fiscal year 1954, also according to past experience. This will leave a net of 19 officers to be retired during the coming fiscal year, bringing the total number of officers on the retired rolls to 257 on June 30, 1954, at a total cost for the year of $1,268,000.

This appropriation does not lapse each year. That is to say, money unused in one year is available for use in the following year. Since it is estimated that $53,000 will be carried over at the end of fiscal year 1953, the amount of the new appropriation needed for 1954 is $1,215,000.

I should add, Mr. Chairman, that a few retired officers have gone to work for other Government agencies and are not now drawing their retirement pay. For that reason it is possible to reduce our request by $18,000. In other words, it now appears that we need to have appropriated $1,197,000 instead of $1,215,000.

Mr. BUSBEY. As I recall it, a year ago you estimated a need for $1,250,000 for fiscal 1953, and the Congress cut that to $1,150,000. Last June you estimated you would need a supplemental appropriation of $48,000, which would bring the total to $1,198,000. And your present estimate for fiscal year 1953 is what amount?

Mr. HARLOW. $1,133,000.

Mr. BUSBEY. So we on the committee made a rather good estimate of your requirements last year when we allowed $1,150,000 in the regular bill, did we not?

Mr. HARLOW. Yes, sir.

Mr. BUSBEY. I presume that if you had some way of telling just how many men were going to take jobs in private industry and not draw retirement pay, and if you knew just how many were going to die, it would help you in making your estimate?

Mr. HARLOW. Yes, that and the fact we have several officers who have enough service to retire voluntarily, and if any considerable number of those should take their option we should immediately have them on the retired rolls, and that would cause us to exceed our estimate here.

Mr. BUSBEY. In other words, from past experience this is your best judgment of what should be appropriated for fiscal year 1954?

Mr. HARLOW. Yes, sir.

Mr. BUSBEY. There is no way you can give the committee any assurance that it is any closer than your estimates for fiscal year 1953?

Mr. HARLOW. The only answer I can give to that question, Mr. Chairman, is to say that we have recalculated it, as I indicated in my opening statement, and now see that we think we can get along with $18,000 less, as provided in this estimate.

PROVISION FOR RECALL TO ACTIVE DUTY

Mr. BUDGE. Is there any provision for recall of these officers to active duty?

Mr. HARLOW. They can be recalled to active duty in time of war with their consent; and of course a man who is retired for disability can be recalled to duty if he recovers from his disability.

Mr. BUDGE. They can only be recalled with their consent? That is different from the Army.

Mr. HARLOW. If they have total retirement, yes.

Mr. BUDGE. It seems to me that is unfortunate. The officers in the Military Establishment can be recalled to active duty when a military program is being built up. And I imagine quite a few of these 257 officers could perform very capably the jobs they have been trained for. It seems to me there should be some provision for arbitrarily recalling them, the same as with the military.

Dr. DRESCHER. When an individual is retired for temporary disability, he may be recalled to duty if he recovers; but we do not have authority at the present time to involuntarily recall a retired officer, nor can he voluntarily come back on duty since July 4, 1952. We hope to reestablish the privilege of having retired officers come back if they have the competency.

Mr. HARLOW. July 4, 1952, is the date on which officers of the Public Health Service ceased to be members of a military organization. In time of war the President has the authority to make the commissioned corps a branch of the military service. That status was terminated on July 4, 1952.

POSSIBILITY OF AMENDING LAW

Mr. BUSBEY. Mr. Harlow, has any thought been given to the possibility of having the law amended so that these officers could be recalled under certain conditions?

Mr. HARLOW. May I ask Dr. Drescher to reply to that?

Dr. DRESCHER. Yes; there has been thought given to it, and we are now in the process of preparing such legislation for consideration as might deal with that and other matters affecting the officers of Public Health Service.

Mr. BUSBEY. Will that legislation be before the proper legislative committee in the near future?

Mr. HARLOW. We would hope so, Mr. Chairman. Of course that has to have the usual legislative clearance through the agency and the Bureau of the Budget, and we are not able to forecast what those attitudes will be.

Mr. BUSBEY. But there is some thought being given in the agency to that problem?

Mr. HARLOW. Yes.

Mr. BUSBEY. Thank you very much, Mr. Harlow.

SALARIES AND EXPENSES

WITNESSES

ROY L. HARLOW, CHIEF FINANCE OFFICER, PUBLIC HEALTH SERVICE
GEORGE PERROTT, CHIEF, DIVISION OF PUBLIC HEALTH METHODS
DR. H. VAN ZILE HYDE, CHIEF, DIVISION OF INTERNATIONAL HEALTH

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$2,913,068	$3,170,250	$3,138,000
Reimbursements from non-Federal sources	2,693		
Reimbursements from other accounts	113,868	601,187	583,801
Total available for obligation	3,029,629	3,771,437	3,721,801
Unobligated balance, estimated savings	−434		
Obligations incurred	3,029,195	3,771,437	3,721,801
Comparative transfer from—			
"Control of venereal diseases, Public Health Service"	75,000	75,000	
"Control of tuberculosis, Public Health Service"	11,103	18,000	
"Assistance to States, general, Public Health Service"	25,476		
"Control of communicable diseases, Public Health Service"	12,000	15,000	
"Hospitals and medical care, Public Health Service"	20,993		
"Commissioned officers, pay, and so forth, Public Health Service"	605,974		
Comparative transfer to—			
"Hospitals and medical care, Public Health Service"	−106,678	−100,000	
"Salaries and expenses, Office of the Administrator, Federal Security Agency"	−43,114	−40,300	
Total obligations	3,629,949	3,739,137	3,721,801

NOTE.—Reimbursements from non-Federal sources above are from the proceeds of sale of personal property (40 U. S. C. 481 (c)).

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
Direct Obligations			
1. Public-health methods and reports	$537,847	$528,000	$528,000
2. International health activities	142,414	137,000	137,000
3. Management and central services	2,638,801	2,472,950	2,473,000
Total direct obligations	3,319,062	3,137,950	3,138,000
Obligations Payable Out of Reimbursements From Other Accounts			
1. Public-health methods and reports	7,728	17,386	
4. Reimbursable details of commissioned officers	303,159	583,801	583,801
Total obligations payable out of reimbursements from other accounts	310,887	601,187	583,801
Total obligations	3,629,949	3,739,137	3,721,801

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Summary of Personal Services			
Total number of permanent positions	683	635	631
Full-time equivalent of all other positions	5	3	1
Average number of all employees	601	595	592
Average salaries and grades:			
General schedule grades:			
Average salary	$4,530	$4,713	$4,707
Average grade	GS–6.4	GS–6.7	GS–6.7
Crafts, protective, and custodial grades:			
Average salary	$2,886	$2,922	$2,911
Average grade	CPC–2.9	CPC–2.9	CPC–2.9
Personal service obligations:			
Permanent positions	$3,054,244	$3,170,080	$3,170,145
Part-time and temporary positions	26,864	23,782	6,396
Regular pay in excess of 52-week base	9,848	9,709	9,644
Payment above basic rates	19,532	40,721	40,721
Payments to other agencies for reimbursable details	300		
Total personal service obligations	3,110,788	3,244,292	3,226,906
Direct obligations			
01 Personal services	2,806,321	2,643,105	2,643,105
02 Travel	61,139	75,800	75,800
03 Transportation of things	5,866	2,500	2,500
04 Communication services	107,423	108,900	108,900
05 Rents and utility services	3,961	4,150	4,150
06 Printing and reproduction	127,789	150,150	150,150
07 Other contractual services	112,487	96,900	96,900
Services performed by other agencies	26,829	2,000	2,000
08 Supplies and materials	35,539	26,800	26,800
09 Equipment	30,224	26,550	26,600
13 Refunds, awards, and indemnities	305		
15 Taxes and assessments	3,231	3,147	3,147
Subtotal	3,321,114	3,140,002	3,140,052
Deduct charges for quarters and subsistence	2,052	2,052	2,052
Total direct obligations	3,319,062	3,137,950	3,138,000
Obligations payable out of reimbursements from other accounts			
01 Personal services	304,467	601,187	583,801
02 Travel	4,140		
03 Transportation of things	1,850		
07 Other contractual services	430		
Total obligations payable out of reimbursements from other accounts	310,887	601,187	583,801
Total obligations	3,629,949	3,739,137	3,721,801

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$420,786	$383,247	$413,497
Obligations incurred during the year	3,029,195	3,771,437	3,721,801
	3,449,981	4,154,684	4,135,298
Deduct:			
Reimbursements received	116,561	601,187	583,801
Adjustment in obligations of prior years	22,013		
Unliquidated obligations, end of year	383,247	413,497	441,497
Obligated balance carried to certified claims account	1,244		
Total expenditures	2,926,916	3,140,000	3,110,000
Expenditures are distributed as follows:			
Out of current authorizations	2,635,554	2,850,000	2,800,000
Out of prior authorizations	291,362	290,000	310,000

Mr. BUSBEY. The last Public Health Service item we have for consideration is "Salaries and expenses of the Surgeon General's Office." Would you like to make a general statement on that, Mr. Harlow?

Mr. HARLOW. Yes. I have a general statement on that item that I would like to make.

GENERAL STATEMENT

Mr. Chairman and members of the committee, this appropriation covers activities of the Bureau Office of the Surgeon General and in addition provides for many program costs that can be handled more economically on a centralized basis. As a result of reductions made by the Congress last year and in line with recommendations included in the report of the Senate Committee on Appropriations the number of activities financed by this appropriation has been reduced from 5 to 3. The activity "Development and coordination of nursing resources" has been transferred to the appropriation "Hospitals and medical care." The line item "General duty and training" has been eliminated from the budget.

PUBLIC-HEALTH METHODS AND REPORTS

The first of the three remaining line items covers requirements of the Division of Public Health Methods to provide a central staff for the Surgeon General for dealing in necessary detail with the many problems related to the Nation's health which cut across the Service's organizational lines. These include such problems as those created in the civilian population by the withdrawal of health personnel for service with the Armed Forces; the problems in relation to facilities and organization which arise from the growing prevalence of chronic disease; the problems of professional and subprofessional education of health personnel to meet changing conditions brought about by technical and scientific advances; assistance to voluntary and professional organizations working within their specific fields to meet these changing conditions. The Division's work is largely of a fact-finding and advisory nature, serving, within the Public Health Service, not only as a supporting staff for the Office of the Surgeon General, but also giving assistance to the several bureaus and divisions on policy, factual, and methodological matters. In addition, the Division edits and publishes Public Health Reports, which is the official journal of the Public Health Service and whose editorial policy is to bring discussions of practical importance to people who work in public-health fields.

INTERNATIONAL HEALTH ACTIVITIES

The funds requested in the second item are needed for the Division of International Health to finance the direct responsibilities of the Public Health Service in technical liaison with World Health Organization and Pan American Sanitary Bureau, development with the Department of State and presentation of United States positions on international health matters, service as a clearinghouse for information on health conditions and needs in other countries, cooperation with national non-Government agencies contributing to the advancement of world health, and related activities.

In addition to those things for which this appropriation is used, the Division of International Health acts as a staffing and technical agency for the health activities of the Mutual Security Agency and Technical Cooperation Administration. This work, however, is financed with funds supplied by the two agencies.

MANAGEMENT AND CENTRAL SERVICES

The last item "Management and central services" provides for the Surgeon General, his immediate assistants, supporting staff offices, and central services that are often loosely referred to as administration or overhead. This terminology has an unfortunate connotation because of the jaundiced eye that is often cast on administrative activities. I think a better term would be "undistributed costs" since most of the charges against this item are incurred for the purpose of supporting programs. They are financed centrally either because careful study has indicated more efficient and economical operation than would be possible on a decentralized basis or because the cost of distributing charges to program would be out of proportion to the cost of the service to be distributed.

ADVANTAGES OF CENTRALIZING ADMINISTRATIVE SERVICES

Last year we brought to the attention of this committee the centralization of personnel activities at headquarters here in Washington. By merging the personnel offices of the Bureau of State Services, Bureau of Medical Services, and the Office of the Surgeon General and by making some adjustment in the personnel program it was possible to reduce the number of employees from 90 to 60. This is an example of economy through centralization although it has the disadvantage of removing part of the cost as a direct charge against program and places it in the undistributed category. Most of the personnel, supply, and fiscal operations found under this activity were so placed because this is the most economical way of handling the problem.

Good examples of these undistributed charges are the switchboard and teletype operations. These items alone, if distributed to the programs which they serve, would account for almost $90,000 of this appropriation.

Mr. Chairman, if there are any questions you have with respect to any of these activities, some of us on this side of the table will make an attempt to answer them.

DIVISION OF PUBLIC HEALTH METHODS

Mr. BUSBEY. Would you give us a little more detail to indicate why you need 80 positions for "Public health methods?"

Mr. HARLOW. Mr. Perrott.

Mr. PERROTT. I am George Perrott of the Division of Public Health Methods.

As Mr. Harlow's presentation said, one of the functions of the Division of Public Health Methods is the publication of our Public Health Service's monthly periodical Public Health Reports. That publication accounts for something under one-third of the total appropriation.

Would you like me to say a word about the Public Health Reports and describe it, sir?

Mr. BUSBEY. Yes.

PUBLICATION OF PUBLIC HEALTH REPORTS

Mr. PERROTT. Public Health Reports, now a monthly publication, was created in January 1952 as a consolidation of some three other publications of the Public Health Service. The old Public Health Reports, whose name the new monthly publication bears, was a weekly publication. There was a publication at our communicable-disease center in Atlanta, called the Communicable Disease Bulletin and then a publication of our Venereal Disease Division on venereal-disease control and statistics. These 3 were consolidated in January of 1952, which resulted in about 1 issue a month instead of something like 7 issues of the former 3 publications, 1 of which was a weekly, and reduced the maximum number of copies a month from some 42,000 to about 12,000, which is the present circulation of Public Health Reports.

Public Health Reports accounts for about $160,000, I believe, annually, of which something over half is for printing and the remainder for personal services.

SPECIAL STUDIES

The remainder of the staff of the Division are engaged in staff work for the Surgeon General and in the making of certain studies which cut across service lines; that is, which do not fall in any particular division of the service.

One of the jobs we have been doing over the past few years is making some studies of the finances of professional education. There is a study of the finances of the medical education and the effect of our Public Health Service's grant programs on medical education, which was made of the schools as of 1947–48 at the request of the National Advisory Health Council.

A similar study of dental schools was made a year or so later with the Division of Dental Resources at the request of the Council on Dental Education, and one on the schools of public health at the request of the Association of Schools of Public Health, which has just been completed.

In the work for the fiscal year ending 1954, for which we are justifying this budget, it is contemplated we will have continuation of some of the type of work which has been done in the past.

We have been asked by the National League for Nursing to make a study of the finances of collegiate schools of nursing, of which there are some 200 in the country.

STUDY OF REGIONAL ORGANIZATIONS OF HOSPITALS

We are also cooperating with the Commission on financing hospital care this year in a study of regional organizations of hospitals, a study which was made at the request of the Commission, and a part of that would remain to be finished in the coming fiscal year.

Mr. BUSBEY. Isn't that work done under the Hill-Burton Act?

Mr. PERROTT. Not this type of study. What we have been doing is a study of about 12 so-called regional organizations which exist in several parts of the country, wherein a central hospital, perhaps affiliated with a medical school, has certain cooperative relations with other hospitals to increase the efficiency of the whole system. This may be no more than some sort of central purchasing system for a group of hospitals. It could, as it sometimes does, go on to include central blood-bank service, perhaps, or central diagnostic facilities available to the smaller outlying hospitals. And some of these organizations might include, if they are affiliated with a medical school, some kind of rotation of internships or residents.

Mr. BUSBEY. It is very confusing to those of us sitting on this side of the table when we hear that so many projects which seem related, in many ways very closely, are being handled by all the agencies of the Government. I got the impression that very much the same type of work as you have described is being done under the Hill-Burton funds.

FUNCTIONS OF DIVISION

Mr. PERROTT. The Division of Public Health Methods is a division set up in the Office of the Surgeon General which has a team of a variety of skills, and it has been our practice when a problem has come along on which it seemed that the skills of some of the staff could be used, when there was nowhere else in the Service for the study to do it in the Division of Public Health Methods.

This was discussed with our Bureau of Medical Services and Division of Hospital Resources in the Bureau of Medical Services, and at the time that the data were needed they were unable to proceed with the study, and it was for that sort of exigency that made Public Health Methods do it. It was done, however, with their knowledge, and their advice.

Dr. DEARING. I wonder, Mr. Chairman, if I could expand on that a little bit.

The way we view this Division of Public Health Methods, which is in our own immediate office, has to do with the whole philosophy and practice of research, whether it be in natural sciences, National Institutes of Health, or in statistical research, which is the sort of surveys which Public Health Methods does.

We find no virtue in centralizing for the sake of centralizing, for bringing together all in one place. The programs, such as the Hill-Burton program, need to carry along with them appraisal and survey techniques directly applied to their work as do others of the operating programs of the Public Health Service. But the Surgeon General has long recognized, and had to meet, a need for staff work in his own office to keep up with and keep coordinated these various surveys, a need to supplement them, and a need to enter into fields which are not so directly related to any particular program. That is the function of the Division of Public Health Methods, and Mr. Perrott's division works with all the other divisions that are doing surveys, is not only aware of their work, but to a degree supervises it in a staff capacity. It is his job, we look to him to keep up with all that is going on everywhere. And when a specific project which is important within our authority comes up anywhere, we look about to see where

it can best be done, and that decision is reached, perhaps, project by project.

(The following statement was furnished for the record:)

USE AND PURPOSE OF INFORMATION SUPPLIED BY DIVISION OF PUBLIC HEALTH METHODS

The following examples demonstrate the use of data from studies made by the Division of Public Health Methods. Such data are requested by the Executive Office of the President, special commissions, congressional committees, and by agencies and individuals outside the Government; they represent information, not generally available elsewhere, which the Public Health Service is expected to supply.

For the development of methods to determine the extent to which physicians may be withdrawn from civilian life for military duty (Health Resources Advisory Committee of the Office of Defense Mobilization).

For the development of data on the location of medical school graduates in relation to their residence before entering medical school (chairman of the council on medical education and hospitals, American Medical Association).

For development of recruitment programs, planning training facilities, revising curricula (national professional associations representing occupational therapists, physical therapists, medical social workers, and medical record librarians).

For consideration of problems of education for the health professions, including costs, staffing, programs, regional and interstate planning (Southern Regional Education Board, Western Governors Conference, and a number of individual universities).

For tabulations of personnel resources and requirements used as a basis for policy decisions and recommendations on training, recruitment, and utilization of physicians (Committee on Specialized Personnel of ODM; The Brookings Institution; National Manpower Council; Association of State and Territorial Health Officers in cooperation with American Public Health Association).

For development of a program for the distribution of limited supplies of influenza vaccine to occupational groups in relation to their essentiality to the community (influenza study program in the United States).

For information, estimates and tabulations concerning a number of causes of illness, not reportable in the States, either on a national basis or according to geographic areas or particular groups of the population (marketing research department of Merck & Co.; Commission on Financing Hospital Care; Clothing Manufacturers Association; Library of Congress; University of Michigan; University of Pennsylvania; Community Studies, Inc., of Kansas City).

Mr. BUSBEY. Pardon me, Mr. Perrott, I believe we interrupted your statement. Is there something you wish to add to that?

Mr. PERROTT. I have gotten a little off base here since we began talking. I was continuing, I think, with saying various projects we undertake in the Division.

Mr. BUSBEY. Yes, in regard to these 80 positions.

Mr. PERROTT. And I had mentioned that a part of that was for the publication of our monthly magazine, Public Health Reports, and then was going on to mention some of the other things we do.

COLLECTION AND ANALYSIS OF MEDICAL MANPOWER DATA

One of the other jobs on which we have been engaged is getting together all available data on manpower, personnel in the medical field, that is, doctors, dentists, auxiliary personnel of one kind or another, X-ray technicians and so on.

We have asked at the time the 1950 census data were being gotten ready for tabulation—we asked the Bureau of Census to make some tabulations of what you might call the health occupations. There are something, I think, like a million and a half or so people engaged in some aspect of health work, including the doctors and the people in hospitals and public health departments and so on.

Part of the job we are going to be engaged in when these special tabulations come through is analysis of that rather large amount of data, which will give us some data on people in the various medical occupations, even including the attendant in the physician's office, for example, or the orderly in the hospital, which we will have by county and by age and sex, and in some detail. This will give some data on the numbers of persons and various types of occupations in the health industry which we have not had before in that detail.

Mr. BUSBEY. Will that data be made available to those who administer the Hill-Burton Act so that they will be able to judge where to put a hospital and whether they will have the staff to run the hospital?

Mr. PERROTT. It will probably be put out in some multilith form, and they will certainly see it as soon as anybody. I think it will be data in more detail than we have had before, county by county, on the availability of personnel of all kinds.

Mr. BUSBEY. When will that study be published?

Mr. PERROTT. We are getting the data. We will probably have the data some time toward the end of this year, the complete data. It probably will not be out, the total data, until some time in 1953. I should say late in 1953.

Mr. BUSBEY. You mean calendar year 1953?

Mr. PERROTT. Calendar 1953, I was thinking of. However, we are getting, piece by piece some of the data. We have just finished the tabulation of the data for the country.

Mr. BUSBEY. That information will be 3 years old when you publish it. Won't the information be obsolete by that time?

Mr. PERROTT. It will still be better than anything there will be because the sources of data on many of these occupations are exceedingly slim. The sources are the data that the professional organizations themselves collect. And while from some of these data—I am excluding now physicians and certain others, where the data are pretty good—you cannot do much more than estimate the total numbers, you possibly can get some estimate by States, but you cannot get down to counties, and you do not know anything about the age composition, for example.

COOPERATIVE STUDIES WITH COMMISSION ON CHRONIC ILLNESS

Mr. BUSBEY. Tell me what is meant by—

the problems in relation to facilities and organization which arise from the growing prevalence of chronic disease.

Mr. PERROTT. That refers to an activity of ours which has been a cooperative endeavor with the commission on chronic illness. The commission on chronic illness is a voluntary organization which was originally sponsored by the American Medical Association, the American Public Health Association, the American Public Welfare Association, and the American Hospital Association. There are four of them.

The commission, established several years ago by those organizations, was established because it was felt there was a need for some organization which considered the whole field of chronic illness rather than considering it by categories, such as heart disease or poliomyelitis or diabetes, because there are certain aspects of the care of

chronic disease that are really common to all chronic diseases—hospitalization, for example, or home care instead of hospitalization, which are common to many of the chronic diseases.

We have been assisting the commission in some of the studies which the Public Health Service wanted to get information on and which the commission also did. That is the reference to our cooperative work for the commission on chronic illness.

INTERNATIONAL HEALTH ACTIVITIES

Mr. BUSBEY. I notice that in addition to the positions the Mutual Security Agency and the Technical Cooperation Administration transfer funds for you carry 25 positions for international health activities. What are the activities that require 25 people in this field?

Dr. HYDE. Mr. Chairman, the activities are set forth in a short prepared statement I have here. I wonder if I might read this.

Mr. BUSBEY. We will have it inserted in the record at this point, and then if you wish to summarize it, please do so.

(The statement referred to is as follows:)

Mr. Chairman and members of the committee, it is our firm conviction that one of the most potent weapons available in the fight against communism is the improvement of the economic and social condition of the depressed peoples in less highly developed countries abroad so that they will no longer be living in such squalor as to make them easy prey to the false blandishments of communism. Improvement of health conditions plays a major and vital role in this effort. Improvement in health releases manpower for the fields and factories, reduces the crushing cost of care of the unnecessarily ill, secures the family and raises the spirit of the individual.

The two avenues available to us in this work are through the World Health Organization, a United Nations agency, and the regional office, and through the direct technical assistance programs of the Mutual Security Agency and Technical Cooperation Administration. The work done by the Division of International Health in the staffing and the technical direction of the Public Health Divisions of MSA and TCA Missions is financed by funds supplied by these two agencies. The funds requested in this appropriation are needed to finance the direct responsibilities of the Public Health Service in technical liaison with WHO and PASB, development with the Department of State and presentation of United States positions on international health matters, serves as a clearinghouse for information on health conditions and needs in other countries, cooperation with national non-Government agencies contributing to the advancement of world health, and related activities.

ACTIVITIES OF DIVISION

Dr. HYDE. The Division of International Health is concerned with the relationship of this Government on a technical level with the international organizations concerned with health, primarily with the World Health Organization and Pan American Sanitary Bureau, and provides technical relationships with them. It assists in the development of the positions of the United States in regard to items on the agenda of their annual meetings, and with regard to their various activities in the technical field, and all the related organizations that are active in the field of health, such as the Children's Fund.

It is also concerned with supporting the Technical Cooperation Administration and the Mutual Security Agency in its programs abroad and furnishes the technical backstopping and support for the missions in some thirty odd countries.

It is also responsible for bringing together the information on health conditions abroad that is the base on which the position in regard to

technical matters in the International Health Organization and the point 4 and MSA programs are worked out.

Mr. BUSBEY. Why should not they reimburse you for those positions?

Dr. HYDE. They do, sir. Two-thirds of the staff of the Division is paid from funds provided by TCA and MSA. The Public Health Service gives the direction to the total international function. For instance, branch chiefs are paid out of this appropriation, whereas the bulk of the staff that does the work in connection with the development of the programs for bilateral agencies, such as TCA and MSA, comes out of the funds made available by them.

Mr. BUSBEY. In the next paragraph you state: "In addition to those things for which this appropriation is used," and then you go on to say, "however, is financed with funds supplied by the two agencies."

Dr. HYDE. The bulk of the activity under this appropriation is in connection with the international organizations, the World Health Organization and the Pan American Sanitary Bureau, and the technical information and liaison with them.

Mr. BUSBEY. Do people from this Division attend some conferences?

Dr. HYDE. Yes, sir.

Mr. BUSBEY. Of the World Health Organization?

Dr. HYDE. Yes, sir. Usually at least three of the members of the Division attend the World Health Assembly, and members of this Division attend the directing council of the Pan American Sanitary Organization, and committees of the latter and work with the World Health Organization.

Mr. BUSBEY. And their principal reason for attending these conferences is to represent the interest of the United States in these matters?

Dr. HYDE. Yes, sir. And this Division helps develop, works very intimately with the State Department in development, of the position of the United States, bringing together the various agencies of the Government and nongovernmental agencies that are concerned with the development of the official United States position in connection with that.

Mr. BUSBEY. All I can say is that I sincerely hope they are more familiar with the position of the United States in these matters than was our delegation at the convention on migration of the International Labor Organization that was held in Naples, Italy, which I attended. The delegates were not even able to state to me the position of the United States.

Dr. HYDE. I would like to say, sir, that the relationship has been very intimate between this Division and the Department of State Division of United Nations Economic and Social Affairs for some several years.

Mr. HARLOW. Before you get away from that item, Mr. Chairman, I would just like to introduce what to me, anyway, seems a little humorous element into this situation.

Mr. BUSBEY. We always like to have a little humor injected into the serious matter of appropriations, Mr. Harlow.

Mr. HARLOW. What I refer to is this: If you remember, the Senate report, I believe, on this particular item said that we ought to get

more money from these organizations for which we do work; they should bear more of the expense of this operation. In another report which dealt with the appropriation to these other agencies, I think they were directed to reduce by 10 percent the amount of money that they contributed to the organizations which were doing work for them. Somewhere along there we seem to have been caught in the middle.

I say that is humorous, but it actually is not funny to us.

FELLOWSHIP PROGRAMS FOR FOREIGN HEALTH STUDENTS AND VISITORS

Dr. HYDE. If I may add one fact, to give some idea of the scope of the work.

This Division handles the trainees from abroad, the fellows and visitors from abroad in the health field for TCA and MSA and the Institute of Inter-American Affairs, and those amounted in fiscal 1952 to 271, and thus far this fiscal year, to 401. For that the Division is reimbursed. However, there are visitors from other sources, such as international agencies, and visitors brought here by their own governments, private expense, and so forth, from a variety of sources, that want to learn something about public health here in the United States. Many of them want to be placed in institutions, schools of public health, and so forth. That group amounted to over 353 in fiscal 1952, and thus far this year, 310. That group is serviced and helped and aided by the Division without any reimbursement from the other agencies, which means a considerable load on the Division.

Dr. DEARING. Mr. Chairman, I would like also to say we should make clear it is our understanding of the intent of the basic legislation establishing the Technical Cooperation Administration, the technical services, which, to be sure, are given under their funds, should be developed and planned and supported by respective technical organizations in health and agriculture. So they very clearly place a responsibility on the technical assistance of the Public Health Service to do some service on its own in addition to the reimbursement service.

1954 BUDGET ESTIMATE

Mr. BUSBEY. You are asking for $3,138,000?

Mr. HARLOW. Yes.

Mr. BUSBEY. Which appears to be a reduction of $32,250 from the 1953 appropriation. But considering the net effects of 3 transfers from other appropriations and 2 transfers to other appropriations, there is only a difference of $50 between the funds available in 1953 and the 1954 estimate.

POSSIBILITY OF REDUCING NUMBER OF TRANSFERS

Is there any possibility of reducing the number of transfers in the future, Mr. Harlow? They are really very confusing to the committee.

Mr. HARLOW. Mr. Chairman, I do not know that anyone could give a positive assurance of that. Certainly we do not make them unless we see that it is information that the committee certainly is entitled to. As long as we have these appropriation accounts involved, it is inevi-

table that consolidations, for example, reorganization changes within the Service, may affect these appropriations.

For example, we issued Public Health Reports as one journal. We could have continued to finance it out of these 3 or 4 different appropriations. Then we get into costly administrative expenses. I say costly. Maybe they would not cost too much, but they would still cost more to handle administratively than if we had it in one fund and paid all of the publishing expenses, all of the editorial expenses, out of one appropriation.

Mr. BUSBEY. I notice that most of this appropriation is for management and central services. Of course, this amount could be easily increased or decreased by shifting more or less of the burden from the bureaus and divisions of this office. I think the important thing is the total amount of administration or overhead in Public Health Service.

PUBLIC HEALTH SERVICE ADMINISTRATIVE COSTS, 1952–54

Therefore, I would appreciate it if you would submit a statement showing the total administrative costs in dollars and man-years for the Public Health Service for 1952, 1953, and 1954, and please provide a breakdown of the 1953 total by the activities—personnel, fiscal, budget, organization and methods, property management, and all other. Will you please submit such information for the record?

Mr. HARLOW. Yes, sir. You may not have it by the time you want the transcript back, but we can certainly supply it.

(The information is as follows:)

Costs of administrative services and executive direction, 1952, 1953, and 1954

Year	Administrative services and executive direction		
	Charged to specific programs	Undistributed charges	Total
1952 actual:			
Man-years	1,048.5	411.3	1,459.8
Cost	$4,034,385	$1,888,201	$5,922,586
1953 estimate:			
Man-years	1,057.6	391.8	1,449.4
Cost	$4,158,143	$1,831,728	$5,989,871
1954 estimate:			
Man-years	1,078.4	389.6	1,468.0
Cost	$4,263,837	$1,832,669	$6,096,506

Analysis of costs of administrative services and executive direction, 1953 estimate

Activity	Administrative services and executive direction					
	Charged to specific programs		Undistributed charges		Total	
	Man-years	Cost	Man-years	Cost	Man-years	Cost
Administrative services:						
Personnel	103.7	$489,970	59.5	$319,084	163.2	$809,054
Fiscal	251.0	941,479	147.3	586,862	398.3	1,528,341
Budget formulation	11.9	64,247	7.5	43,495	19.4	107,742
Organization and methods	9.6	51,800	33.0	154,865	42.6	206,665
Property management	322.4	1,234,597	51.9	236,354	374.3	1,470,951
Other administrative services	359.0	1,333,746	54.6	180,642	413.6	1,514,388
Total, administrative services	1,057.6	4,115,839	353.8	1,521,302	1,411.4	5,637,141
Executive direction	0	0	38.0	294,754	38.0	294,754
Total personal services for administrative services and executive direction	1,057.6	4,115,839	391.8	1,816,056	1,449.4	5,931,895
Objects other than personal services		42,304		15,672		57,976
Total cost		4,158,143		1,831,728		5,989,871

TRAVEL AND AVERAGE GRADES

Mr. BUSBEY. While it is a relatively small item, I could not help noticing that in 1952 you had 683 positions, and the travel costs of the office were $61,139, whereas in 1953, with a decrease in personnel of 48 positions, your travel costs are increasing to $75,800. Why, with fewer people, should travel costs increase over 20 percent?

Mr. HARLOW. Offhand, I do not have an answer to that one. You are speaking of this total appropriation or of the management and central-service item?

Mr. BUSBEY. For the total 683 positions.

Mr. HARLOW. That would involve three activities then. We will take a look at this, Mr. Chairman, and see what happens.

Mr. BUSBEY. I notice, too, that your average grade is going up. Why?

The average grade in 1951 was 6.1; in 1952 it was 6.4; now it is 6.7.

Mr. HARLOW. That would require a good deal of work to get at the bottom of that, Mr. Chairman. The grade structure, of course, is undergoing constant revision. In fact, I think the Whitten amendment requires us to make a survey at least once a year, and as these various changes take place, some go up and some go down, and the average is affected one way or the other.

Mr. BUSBEY. Will you provide a brief explanation for the record, please?

Mr. HARLOW. Yes, sir.

(The information is as follows:)

INCREASE IN TRAVEL

The increase in travel between fiscal years 1952 and 1953 is associated with a reduction in positions and a net savings in appropriated money that was accomplished by the decentralization of certain activities to the field and the centralization of responsibility for internal control in the Office of the Surgeon General.

The additional travel due to this change in method of operation was for the following purposes:

1. Audit of fiscal records of field-accounting points.
2. Audit of property-accounting records.
3. Supervision of decentralized personnel activities.

INCREASE IN AVERAGE GRADE

The average grade was based on 849 positions in 1951, 683 positions in 1952, 635 positions in 1953, and 631 positions in 1954. This significant reduction in staff was accomplished after considerable study for the purpose of adjusting methods of operation and areas of responsibility in the interest of efficiency and economy. The changes resulted in an overall savings but also caused an increase in average grade because (1) many of the positions dropped involved routine functions in lower grades; (2) increased responsibilities due to realinement of functions raised the classification of some positions; and (3) in some cases better utilization of personnel was accomplished by the substitution of high level, nonprofessional civil-service employees for commissioned officers in scarce professional categories. The salaries of commissioned officers are not involved in the computation of average grade.

TREND TOWARD CENTRALIZATION OF ADMINISTRATIVE SERVICES

Dr. DEARING. I think there is one point that might be made, Mr. Chairman. Our trend in organization the past few years has been to centralize some responsibilities in the Office of the Surgeon General. They have been in the nature of staff and supervisory and standard-setting responsibility, at somewhat higher level than operations. We have attempted to get operations back more closely to the programs, and that would give a relative increase in the grade structure in the Surgeon General's office.

LANGUAGE CHANGE

Mr. BUSBEY. There is one more item here. That is the language in the bill which proposes elimination of the phrase "and with the approval of the Bureau of the Budget." What is the reason back of that change?

Mr. HARLOW. That represents a change in the policy of the Bureau of the Budget itself, Mr. Chairman. They have said they are not interested in the actual approval of these transfers since under the act which deals with the apportionment of funds, they have to approve the apportionment of any money that we use before we can spend it.

Mr. STEPHENS. May I just add this to that? When that was put in there, it was on the occasion we used to have an appropriation for the pay of commissioned officers. With connivance and counsel of this committee, it was decided to put the pay of commissioned officers in several units, like Hospital Division, Quarantine Division, where they belong. Frequently during the year the Surgeon General has to shift officers. He might in emergency move a group of officers out of the Hospital Division to someplace where he needed them more extremely. This would give him authority on his own to move the money along with the officer. It would have been appropriated in a certain unit, and if he moved the officer, he could move the money along with him.

Mr. BUSBEY. Thank you very much, gentlemen.

Mr. HARLOW. Thank you, Mr. Chairman.

May I say, since this is the last Public Health Service item, that we certainly appreciate the courtesies that you have extended to us, also

those which have been evidenced to us by the other members of the committee.

Mr. BUSBEY. Thank you again.

TUESDAY, APRIL 14, 1953.

STATEMENT OF THE SECRETARY

WITNESSES

HON. OVETA CULP HOBBY, SECRETARY
RUFUS E. MILES, JR., DIRECTOR OF ADMINISTRATION
PARKE M. BANTA, GENERAL COUNSEL
M. A. STEPHENS, BUDGET OFFICER

REVISION OF BUDGET ESTIMATES, 1954

Mr. BUSBEY. The committee will come to order.

We have under consideration this morning the revision of the budget request for the new Department of Health, Education, and Welfare. Mrs. Hobby, we welcome you to this committee as the first Secretary of that Department. I might comment that it did not take your telephone operators very long to get used to saying the "Department of Health, Education, and Welfare," because I called this morning and the girl on the switchboard announced it just as if she had been saying it for years.

I believe you have a general statement that you would like to make to the committee to start the proceedings this morning.

Secretary HOBBY. Yes, sir; I have.

GENERAL STATEMENT

Mr. Chairman and gentlemen of the committee, two major events of direct interest to you have occurred since I last appeared before you on February 24. One involves a complete reevaluation and a consequent revision of our appropriations requests for the 1953–54 fiscal year. The second is the fact that as of last Saturday, the Federal Security Agency became the Department of Health, Education, and Welfare. FSA no longer exists.

Before discussing the revised budget figures, I would like to thank the Congress, through you, for taking such prompt action in making the Agency a Department. This action should result in more efficient and better administered operations. It is also germane for me to point out that with departmental status it will be necessary to change the names of some offices on your budget sheets.

REVISION OF BUDGET ESTIMATES

When I was before this subcommittee on February 24, I told you we were in the process of reviewing the original 1954 budget prepared by the previous administration. Since that time, the heads and the budget officers of each agency in the Department and I have weighed the needs of the people relying on our programs against the necessity of balancing the budget and eventually relieving the burden on all of our taxpayers. This has not been an easy task. The programs of the Department of Health, Education, and Welfare are concerned, probably, with more individuals on a personal basis than any other

part of our Government. The wishes of the heart were in constant conflict with the hard facts of an unbalanced budget. We have tried to concentrate our cuts on those items that seemed to us could be cut with the least real harm to our diversified and necessary programs. Our revisions are designed to tighten-up operations, pare down the cost of programs but not eliminate them, and to restrict construction to only the most urgent projects.

Of the $1,786,528,761 requested for FSA in the so-called Truman budget, 75 percent or $1,340,000,000 was for public assistance grants provided by law. These grants are a fixed obligation of the Government. Deducting this $1,340,000,000 item left 25 percent of our budget or a total of $446,528,261 on which to probe for soft spots and effect savings.

On February 24, I gave you my assurance that we would review and study all facets of our operations, and in so doing, we would save money everywhere it was possible. On that same day I gave you assurance that we would cut away every cent that is not producing the results which the Congress intended. In presenting to you these revised figures, Mr. Chairman, we have attempted to keep these assurances. The resultant cut is more than $60,000,000, approximately 14 percent of items which are not fixed obligations and over which we have control.

In my former statement I said that we were making studies to determine where operations could be tightened to avoid waste, duplication, and inadequate management. That process, Mr. Chairman, is a continuing one and will be for many months to come.

Since you already have heard all of the items in the Department's estimate except the four appropriations formerly included in the Office of the Administrator group, I presume you will not expect to call back all of the units for another series of hearings. Before discussing the items supporting my own immediate office, I would like to take time to summarize the important reductions made in some of the other items in the bill.

ADJUSTMENTS IN 1954 BUDGET

HOWARD UNIVERSITY

At Howard University a reduction of $215,000 in salaries and expenses has been recommended. This reduction is intended to be in line with the decline in the enrollment. A reduction of $25,000 in plans and specifications is also recommended. One item in the budget on which we have not yet reached final conclusions is the estimate of funds needed for the construction of certain previously authorized buildings. The recommendation in respect to this matter is being developed as rapidly as possible and will be transmitted to your committee shortly.

Mr. Chairman, that has to do with the biology greenhouse and the pharmacy building, and I believe some additions to the science building. That is one category. Another is a building for the law school. We have made some investigation, and there is serious question as to whether or not the American Bar Association would withdraw accreditation from the law school at Howard. So we are developing the facts on that.

OFFICE OF EDUCATION

In the Office of Education, the largest change is a reduction of 25 percent in the George-Barden Act funds, $4,624,391. Reductions of $324,000 in salaries and expenses, or approximately 10 percent of that item, and $3,500,000, 5 percent, in the original $70,000,000 estimate for payments to school districts have been made. The reductions in grants for vocational education are in no way a reflection upon the importance and value of this program but stem from a conviction that the States and local communities throughout the Nation are in better position, fiscally speaking, to assume this part of the total cost of these programs than is the Federal Government.

At this time I have two letters from the Bureau of the Budget which I should like to read into the record, if I may.

Mr. BUSBEY. Surely.

Secretary HOBBY. The first letter is dated April 13, 1953:

MY DEAR MRS. HOBBY: Reference is made to my letter of April 9, 1953 transmitting revised 1954 budget estimates. The allowance contained in that letter for the appropriation "Office of Education, further endowment of colleges and the mechanic arts" has been revised from $1,250,750 to $2,501,500.

The second letter is also dated April 13, 1953:

MY DEAR MRS. HOBBY: As indicated in an amended letter of allowance, which will be sent separately, the revised 1954 budget will contain no reduction in the appropriations for the colleges of agriculture and the mechanic arts.

Considering the firmness of plans for most college programs in the next academic year, it would appear advisable to postpone any proposal to readjust the Federal appropriations until the State legislatures have had an opportunity to increase State appropriations for support of these colleges. In most cases the next meeting of the legislatures will be held in the spring of 1955.

Although the Bureau of the Budget inclines to the belief that the permanent appropriation has become an anachronism and that the annual appropriation first established in 1935 as a depression measure, has outlived the acute need which prompted its original enactment, the issues involved are clearly within the fields to be studied by the proposed Commission on Governmental Functions and Fiscal Resources. We recommend, therefore, that the Commission be asked to study the question of whether the Federal Government should withdraw its financial support from the colleges of agriculture and the mechanic arts after the fiscal year 1955.

VOCATIONAL REHABILITATION

The vocational rehabilitation program should not, from a practical point of view, be reduced. The program is one which actually pays substantial dividends both physical and spiritual to the individuals involved and indirectly to the Federal Government and to the States. It rehabilitates people so they can again become wage-earning, tax-paying individuals. A study of the basic law under which this program operates is now in progress. Under the present law, all administration in the States is paid by the Federal Government; it is, therefore, incumbent upon officials of this Bureau to make careful and continuing checks on State operations. This cannot be done adequately if the staff of the Bureau is reduced to a point where there is no time left for review of State plans and of operations in the States.

PUBLIC HEALTH SERVICE

In the Public Health Service, there are more than 20 appropriations. The total reduction in PHS is $51,228,000. This cuts the Truman 1953–54 budget for Public Health from $270,893,000 to $219,665,000.

An item of $15 million for research construction grants has been eliminated in the light of our governmentwide policy to hold construction to a minimum. This $15 million reduction is shown in detail in the various appropriations of the National Institutes of Health. This $15 million deletion leaves an additional $36,228,000 to come out of other estimates all along the line. In venereal disease and tuberculosis, sharply declining morbidity and mortality rates suggest a reduction of $3,500,000 in these appropriations. The item of $900,000 for water pollution grants was eliminated. Under the hospital-construction-grant program, the reduction was from $75 million to $60 million in the revised estimate, again in line with our restrictive policy on construction. In the hospitals and medical care program the reduction is $1,700,000. This will necessitate the closing of at least three Public Health Service hospitals and a shift of some of the remaining patients to other PHS hospitals. The Veterans' Administration is reducing a substantial portion of the reimbursable load we have received from that organization. The closing of the hospitals may possibly result in some contract services for public-health beneficiaries and Bureau of Employees' Compensation cases.

NATIONAL INSTITUTES OF HEALTH

In the National Institutes of Health, speaking of all of them as a unit, the original estimate was for $85 million. That has been reduced to $56,340,000. Of course, the $15 million for construction grants, mentioned a moment ago, is a part of that reduction. The clinical center opening has been rescheduled to July 1 and will expand gradually throughout the coming fiscal year. By July 1, 1954, it is expected to have approximately 275 beds. The matter of opening the center was discussed at length with the Bureau of the Budget, and the opening was delayed somewhat until a firm decision was made as to the scope and extent of operations in 1954.

SOCIAL SECURITY ADMINISTRATION

In the Social Security Administration the estimate for the Bureau of Old-Age and Survivors Insurance has not been changed because backlogs are already too large. To reduce the 1954 estimate below the original amount would be simply to pile up greater backlogs and increase the time lag between filing of claims and payments to beneficiaries. I discussed this problem when I appeared before you on the 1953 supplemental appropriation bill. The $1,340,000,000 for grants for public assistance, which I discussed at the outset of my testimony today, was left as originally estimated. Any other course would require submittal of a supplemental request. Salaries and expenses for the Bureau of Public Assistance were left at $1,650,000. We should have adequate personnel to see that payments made to the States for administrative expenses are held to a reasonable level and to help the States to avoid payments to ineligibles. A carryover of funds from previous years makes possible a reduction of $2 million in Children's Bureau grants, compared to the Truman budget while holding the total program at an approximately even level with former years.

The last four items in the bill—the ones on which you have not yet held hearings—are titled "Salaries and expenses, Office of Adminis-

trator," "Salaries and expenses, Office of Field Services," "Salaries and expenses, Office of General Counsel," and "Surplus Property Disposal." In my testimony, I will refer to these as departmental rather than as agency units.

EFFECT OF REORGANIZATION PLAN UPON OFFICE OF THE SECRETARY

In advance of a more detailed statement on the appropriation "Salaries and expenses, Office of the Secretary," I should like to explain the effect of the reorganization plan upon the Office of the Secretary. A major purpose of the plan was, of course, to strengthen the leadership and management functions and facilities of the Department. Such strengthening is vital to the operation of the Department in accordance with the management principles advocated by the Hoover Commission.

Briefly, the reorganization plan has abolished the position of Administrator, Assistant Administrator, and Assistant Administrator for Program of the Federal Security Agency. It created a Secretary, Under Secretary, two Assistant Secretaries, and a special assistant to the Secretary (for Health and Medical Affairs). It transferred all the powers and duties of the former Federal Security Administrator to the Secretary and added one other power—the power to centralize administrative services to the extent necessary to achieve economy and efficiency.

COORDINATING RESPONSIBILITIES OF ASSISTANT SECRETARIES

The duties of the Secretary and Under Secretary need little explanation, but I would like to discuss briefly the responsibilities of the two Assistant Secretaries and the special assistant to the Secretary. Each of the Assistant Secretaries will have responsibility for certain functions which cannot be assigned to any single agency of the Department. There are many functions which require that coordination be effected by the Office of the Secretary because related activities exist within the different agencies of the Department. Here is a partial list of activities of a coordinating character:

1. Coordination of the Federal-State relations which are involved in programs of the Public Health Service, the Office of Education, the Social Security Administration, and the Office of Vocational Rehabilitation.

2. Development of departmental policy in respect to matters of proposed legislation and the numerous legislative reports which the Department is called upon to submit. These reports frequently have policy implications of departmentwide importance which makes impossible assignment of responsibility to any one of the constituent agencies.

3. Liaison with private agencies. There are more private agencies organized on a nationwide basis concerned with health, education, and welfare than I ever knew existed—literally hundreds of them. All of them feel, quite understandably, that they should see that their points of view are fully understood by the Department—and particularly by the Secretary—of Health, Education, and Welfare. The amount of this work, and the need for able help in handling it, is far greater than most people realize.

4. International activities with policy functions in the Office of the Secretary and operating functions in the Public Health Service, the Office of Education, the Social Security Administration, and other constituents.

5. Defense planning and liaison involving assignments of responsibility from the Office of Defense Mobilization, the Federal Civil Defense Administration, and liaison with the Department of Defense and Department of State.

6. Coordination of activities concerned with problems of aging. Virtually all of the constituents of the Federal Security Agency are concerned in some manner with problems arising from the steadily increasing proportion of aging in our population. Coordination and leadership of these activities through a Committee on Aging in the Office of the Secretary is necessary.

In addition to these functions, the Department has need for considerably improved contact with Howard University, Columbia Institution for the Deaf, and the American Printing House for the Blind.

These are some of the most important functions to be performed by the Assistant Secretaries with the help of appropriate staff. The extent and importance of the work involved in carrying out these functions properly is not easy to convey. We have not yet reached a firm decision on the division of these responsibilities between the two Assistant Secretaries. That will depend in part upon the special backgrounds and qualifications of the two individuals appointed to these positions.

DUTIES OF SPECIAL ASSISTANT TO THE SECRETARY

The special assistant to the Secretary (Health and Medical Affairs) is a staff adviser to the Secretary. In respect to the development of policy in the health and medical field, he will not have any administrative duties. He will, however, have the important responsibility of examining policy issues in respect to the medical programs of the various constituents of the Department and of advising the Secretary concerning these issues. He will also be concerned with the development of policy recommendations whenever new programs are proposed in the health field.

The impetus toward improved management which was reflected in the reorganization plan makes necessary the strengthening of the top staff to establish and maintain the standards of efficiency which the Congress and the public have a right to expect from a Department. This means, among other things, better, prompter reports, improved budgeting, and more studies of internal organization and procedures.

RESPONSIBILITIES OF DIRECTOR OF ADMINISTRATION

In order to strengthen departmental management I have established, with the approval of the Civil Service Commission and the President, a position of Director of Administration. This official will, in addition to directing the administrative services of the Department, work particularly closely with the Under Secretary and the Assistant Secretaries in relating management operations of the Department to policy development and planning. For example, if management

studies indicate that greater program effectiveness and economy could be achieved through reasonable modifications in existing law, he will work with the other top officials in bringing these matters to the attention of the Congress. Maximum economy and effectiveness clearly indicate the need for limited additional staff to improve these management functions.

GENERAL AUTHORITY TO TRANSFER APPROPRIATIONS

In connection with our efforts to strengthen departmental management, I wish to emphasize the desirability of obtaining a reasonable degree of flexibility through the provision in appropriation language of authority to make small transfers of funds. It is my understanding that the other Department which comes under the jurisdiction of this subcommittee—namely, the Department of Labor—has authority to make such transfers. If, for example, a management study could be undertaken by an outside firm to make certain kinds of determinations and recommendations concerning the operations in the Department, the flexibility provided by this transfer provision might well enable us to conduct the management survey without asking the Congress for any special funds for that purpose. We would, furthermore, not be seriously embarrassed by situations which arise from time to time, such as the obligation to make heavy terminal-leave payments out of small appropriations. I consider such a transfer provision as being very important to the most effective management of the Department. I assure the committee that the transfer provision will be used with great care and circumspection.

Mr. Miles, Mr. Stephens, Mr. Banta, and other officials are here to provide you with detailed explanations of the various appropriations which come under the Office of the Secretary. If I can be of assistance at any time, please feel free to call on me.

Thank you, Mr. Chairman and members of the committee. Before you begin questioning me, could I have the privilege of speaking to you on a matter which, for the time being, I would prefer to keep out of the record. I am sure you will agree with me after I have made this off-the-record statement.

Mr. BUSBEY. Off the record.

(Discussion off the record.)

PROPOSED REDUCTIONS FOR VOCATIONAL EDUCATION

Mr. BUSBEY. On page 3 of your statement you make mention of the fact that in the Office of Education the largest change is a reduction of 25 percent in the George-Barden Act funds. Does that mean a 25-percent reduction in each of the various activities that come under the George-Barden Act, such as agriculture and distributive education?

Secretary HOBBY. Mr. Stephens, do you want to answer that?

Mr. STEPHENS. Yes. The money appropriated after the 25 percent is deducted is designed to be distributed according to the basic law.

Mr. BUSBEY. So, each of the activities under the George-Barden Act would get a 25-percent reduction?

Mr. STEPHENS. Not necessarily. Some States get a minimum, and there would be no reduction there. But the distribution would be a 25-percent reduction in all categories.

SALARIES AND EXPENSES FOR VETERANS' EDUCATIONAL PROGRAM

Mr. BUSBEY. I notice a reduction of $324,000 in salaries and expenses of the Office of Education. Does this include an appropriation for the veterans' program under Public Law 550?

Mr. STEPHENS. Yes, sir, it does. It is carried as one of the minor activities in the Office. I do not have the Office of Education's new revised estimates, but it is less than $100,000.

Secretary HOBBY. As I recall, Mr. Busbey, it is $92,000.

Mr. BUSBEY. I would be very much interested in learning how the $92,000 was arrived at and what is to be done with the $92,000.

Secretary HOBBY. Will you make that available to Mr. Busbey?

Mr. STEPHENS. I can get it up this afternoon or tomorrow morning, or put it in the record when the transcript comes down.

Mr. BUSBEY. I would like to have it inserted in the transcript and also have a copy sent to me.

Mr. STEPHENS. Yes, sir.

RELATIONSHIP OF OFFICE OF EDUCATION AND VETERANS' ADMINISTRATION

Mr. BUSBEY. I appreciate the fact that under Public Law 550 the Veterans' Administration should consult the Office of Education on certain matters, but I cannot help wondering why it was considered necessary to have such a large appropriation as the original one requested for the services the Office of Education expects to perform for the Veterans' Administration. In addition, I am wondering why the Office of Education should not be able to absorb in its regular plan of duty any reasonable request that might come from the Veterans' Administration.

Secretary HOBBY. We can spell that out for you, Mr. Chairman.

Mr. BUSBEY. If you will, please.

(The information follows:)

BUDGET FOR FISCAL 1954, VETERANS' EDUCATION SERVICES

The budget for veterans educational services in fiscal 1954 totals $92,000.

The total revised budget of the Office of Education calls for reductions in many units of the Office. Some of these units were reduced in staff during fiscal years 1952 and 1953. It would not be possible to absorb the costs of the Veterans educational services unless additional statutory and other essential functions of the Office are eliminated.

Explanation of requirements

01	Personal services	$71,230
	1 program supervisor, GS–14.	
	1 specialist, GS–13.	
	3 field representatives, GS–13.	
	1 research assistant, GS–11.	
	1 secretary, GS–5.	
	5 secretaries, GS–4.	
02	Travel	16,550
04	Communication services	1,940
06	Printing and reproduction	800
07	Other contractual services	400
08	Supplies and materials	480
15	Taxes and assessments	600
	Total	92,000

The estimate provides a total of 12 position, 6 professional and 6 clerical; the 6 professionals would be used as follows:

A. One program supervisor who would be responsible for the administration and direction of the activity. He would be a working supervisor with prime responsibilities for the accreditation function and for furnishing technical advice and assistance on special educational problems. There would be 1 professional and 1 research assistant dealing with problems of accreditation.

B. Three field representatives with headquarters in Washington, whose functions would be to deal on a nationwide basis with problems involved in the administration of Public Law 550 by the State-approving agencies. These three field representatives would be able to review the operations only in a limited number of States in which special problems arose.

The House Veterans' Affairs Committee which wrote Public Law 550, and the State educational authorities who testified before the Congress when the bill was passed, contemplated that the Office of Education would conduct an educational audit of the activities of the 48 States to insure compliance with the intent and purposes of Public Law 550. Sponsors of the act laid much stress on the abuses under the previous GI legislation and the tremendous amount of tax dollars wasted. The role of the Office, as originally interpreted by the House Committee on Veterans' Affairs, the Bureau of the Budget, and the Veterans' Administration, would involve an annual impartial review by the Office of the operations of the 81 State-approving agencies. The limited field staff which would be available under this budget would not permit a review of the work of the 48 States but would allow only a spot check or sample review of the State-approving agency activity. The services to the State-approving agencies on technical educational problems would also be curtailed.

PAYMENTS TO SCHOOL DISTRICTS UNDER PUBLIC LAW 874

Mr. BUSBEY. In regard to the original estimate you mention of $70 million for payments to school districts, is that the so-called Eisenhower or revised budget figure, or is it the Truman budget figure, as we have been calling it?

Mr. STEPHENS. That was both at the outset. That was in the Truman budget at $70 million and in our first discussion with the Bureau of the Budget it was tentatively decided to let it stand, because of certain applications that had been received indicating a trend. After second consideration, on another go-round, it was decided that in the light of that being a firm estimate under old conditions, there should be at least a 5 percent reduction, because of the reduction of general costs and of defense spending.

Mr. BUSBEY. That is taking into consideration the applications received and not the applications approved?

Mr. STEPHENS. That is right. The applications when this reduction was made did not seem too encouraging; however, afterward the applications piled up pretty severely. Whether they are firm applications will have to be decided by the Office of Education after they complete processing them.

Mr. BUSBEY. The revised budget, then, would be $66,500,000?

Mr. STEPHENS. Yes, sir.

USES OF FUNDS

Mr. BUSBEY. How much of that $66,500,000 would go for new applications?

Secretary HOBBY. You mean how many entitlements we have in the shop now?

Mr. BUSBEY. I was trying to determine what your obligations are for schools eligible at the present time and what percentage that

would be of the $66,500,000, and what percentage would be left for new applications.

Mr. STEPHENS. I will have to get that from Mr. Lillywhite. However, the applications we have now, a lot of them are to be processed out of the money appropriated for 1953, because in this school maintenance and operation program it is usually after the fact that the funds are paid out. The money appropriated in a given fiscal year is usually not spent until the fiscal year is over or well past over.

(The following additional information was submitted later:)

Estimate of requirements for Public Law 874, fiscal years 1953 and 1954

Section	Revised estimate 1953 [2]			Revised estimate 1954 [2]		
	Average daily attendance	Rate [1]	Entitlement	Average daily attendance	Rate [1]	Entitlement
Eligible applicants			2,300			2,600
Sec. 2:						
Entitlement			$270,000			$285,000
Deductions			6,000			10,000
Net amount			264,000			275,000
Sec. 3:						
3 (a)	90,600	$137.50	12,457,500	99,660	$144.50	14,400,870
3 (b)	658,250	60.00	39,495,000	789,900	63.00	49,763,700
3 (e)	39,330	95.00	3,736,350	42,213	100.00	4,221,300
3 (f)			100,000			100,000
Gross amount			55,788,850			68,485,470
Deductions			−4,647,500			−5,112,250
Net entitlements			51,141,350			63,373,620
Sec. 4:						
4 (a)			3,000,000			4,000,000
4 (b)			2,840,000			1,420,000
Total			5,840,000			5,420,000
Sec. 6 (+8a)			3,500,000			3,750,000
Total requirements			60,745,350			72,818,620
Appropriation or request			60,500,000			[3] 66,500,000

[1] Local contribution rate.
[2] Does not include additional amounts required for provision added to 1953 supplemental appropriation authorizing payments to children of parents who cross State lines to work for Defense Department on Federal property, approximately $300,000.
[3] Request reduced to $66,500,000 due to uncertainty of effect of defense spending.

ADEQUACY OF REVISED ESTIMATE

Mr. BUSBEY. Is there a firm resolve to operate within the $66,500,000 amount, or are you just postponing a portion of the appropriation until a supplemental request is made?

Mr. STEPHENS. I would say from my knowledge it is a firm resolve, based on two factors, that the general costs are receding somewhat, and defense spending is not anticipated to be as strong in 1954. There is a section of that law that provides for a prorating of that amount if the amount appropriated does not meet fully the amount of entitlements. However, this year the Office of Education feels that the $60,500,000—$40 million in the original and $20,500,000 in the supplemental—will about do the job in fiscal 1953.

Secretary HOBBY. May I ask Mr. Miles to relate this figure to the proposed bill that we sent up? I think it might be helpful.

BUDGETARY EFFECT OF PROPOSED LEGISLATION EXTENDING PROGRAM

Mr. MILES. Mr. Chairman, the Congress now has before it a bill recommended by the administration which would amend Public Law 874 and extend it for 2 years. The total effect of that bill would be to reduce the overall cost to an estimated $55 million in 1954. So that if the Congress should enact that bill, instead of having a cost of $66,500,000, the cost would be $55 million.

Mr. BUSBEY. For fiscal year 1954?

Mr. MILES. For fiscal 1954; yes.

Mr. BUSBEY. I am interested in getting some assurance from the Department that if the $66,500,000, or $55 million under the proposed revision of Public Law 874, is appropriated by the Congress, the Office of Education will not be before Congress for a supplemental appropriation. Is there anyone who can give us such assurance?

Secretary HOBBY. May I ask a question? If there are other entitlements which should exceed this sum, would the committee not like to know of schools that would qualify under the law even if it exceeded this amount?

Mr. BUSBEY. Do you mean by that the applications now on file that have not been processed?

Secretary HOBBY. No. There were actually some schools which would have received entitlements but their applications had not yet been received in the Office. As I remember the discussion with Mr. Lillywhite, he thought we could provide for those present entitlements, and with the supplemental appropriation that the total sum would probably meet the late entitlements, as well.

Mr. BUSBEY. That would show up in the statement which Mr. Stephens is going to furnish for the record; would it not?

Secretary HOBBY. Yes.

Mr. BUSBEY. So the committee will have the advantage of studying that after it is submitted.

Secretary HOBBY. They did prepare for me a memorandum on this subject, Mr. Stephens, which outlines this whole thinking. I think it would be very easy to give that to the committee.

Mr. BUSBEY. I think that the Congress has an obligation to do its appropriating for the fiscal year when it passes on the budget for that fiscal year. I personally believe that there have been all too many supplemental appropriation requests coming to Congress. Of course, I cannot speak for the rest of the committee; I can only speak for myself. Personally I am very much against so many additional supplemental requests coming before the Appropriations Committee. I think that we ought to handle appropriations all at one time, unless there is some new law which is passed by Congress after the appropriations are made or some special circumstances which could not have been considered at the time the original budget was being considered.

Secretary HOBBY. Mr. Chairman, I certainly agree with that philosophy. I think we should only present true emergency measures as supplementals.

1953 FURLOUGH WITHOUT PAY FOR OASI STAFF

Mr. BUSBEY. With regard to the estimate for the Bureau of Old Age and Survivors Insurance, which you refer to in the second para-

graph of page 5 of your statement, I recall that in one of the papers last week mention was made of the fact that the Bureau officials were planning a 2- or 3-day furlough without pay for their whole staff; is that true?

Mr. MILES. In the Bureau of Old-Age and Survivors Insurance, Mr. Chairman, that is one of the alternatives they are considering in connection with the need to keep within the existing appropriations.

Mr. BUSBEY. Without any additional appropriations for fiscal year 1953 it is your opinion that they will have to furlough the entire staff for approximately 2 or 3 days without pay?

Mr. MILES. It depends, Mr. Chairman, upon the rate of turnover. If they should lose more people or lose them at a faster rate than they expect to then it may not be necessary. We will not know that for another month or so, toward the end of May, perhaps.

Mr. STEPHENS. Mr. Chairman, that difficult situation which they are analyzing and trying to live with the remainder of this fiscal year points up one factor: The Bureau of Old-Age and Survivors Insurance can with a short staff and funds defer a lot of workloads. They can put off a lot of things until the next fiscal year. That is the main reason, I think, which prompted both the Bureau of the Budget and the Secretary to sustain the original estimate, the first 1954 estimate of $64 million, because they knew definitely they were facing some pileup of backlogs which would of necessity be carried over into 1954.

LANGUAGE RELATING TO CARRYOVER OF CHILDREN'S BUREAU GRANT FUNDS

Mr. BUSBEY. Now, with regard to the last sentence on that page, which reads as follows:

> A carryover of funds from previous years makes possible a reduction of $2 million in Children's Bureau grants compared to the Truman budget, while holding the total program to approximately an even level with former years.

Are you recommending in the revised budget that the language which is objectionable to this committee be eliminated?

Mr. STEPHENS. That language, Mr. Chairman, will not be necessary.

Secretary HOBBY. It expires. Excuse me, Mr. Stephens.

Mr. STEPHENS. That is right. In other words, it would be applicable in 1954 because of the old social-security law allowing carryover for 2 years. The carryover mentioned here is the remainder of 1952 money, which is available under the law through 1954, but after that the law itself will not be necessary because the original enactment in the appropriation language said "hereafter." That means that after 1954 the language would be applicable even though you delete it from the language in the committee print.

SOURCE OF FUNDS FOR INTERNATIONAL ACTIVITIES

Mr. BUSBEY. At the bottom of page 7 you mention international activities. How much money will the Department receive from the various agencies of Government for all these international functions?

Secretary HOBBY. The total budget for that activity, Mr. Busbey, was something like $5½ million. The figure of $5,626,000 sticks in my mind. That comes from the MSA and the State Department.

The figure on transfers from other agencies during the current year is $6,405,176.

Mr. BUSBEY. How was that broken down?

Secretary HOBBY. The Department of State point 4 program is $4,528,124. Then the Department of State educational exchange program is $1,014,900. The Mutual Security is $855,442. The Department of Defense Ryukyuan program is $6,710.

If you would like, this whole table could be put in the record.

Mr. BUSBEY. Without objection, we will put that table in the record at this point.

(The information is as follows:)

Financed from funds transferred or anticipated from other agencies for technical cooperation and exchange of persons activities as of March 31, 1953

Office or Bureau	Department of State, point 4 program				Department of State, educational exchange program		
	Number United States staff	Number staff abroad	Estimated trainee workload	Amount	Number United States staff	Estimated trainee workload	Amount
Office of the Secretary	13	(189)	[1] (556)	$61,131	4	[2] (2,022)	$16,000
Social Security Administration	15	18	66	373,283	3	26	25,708
Office of Education	23	51	134	1,405,628	47	1,946	951,192
Public Health Service:							
Division of International Health	33	109	340	2,523,131	2	50	22,000
National Office of Vital Statistics	6	10	13	150,825			
Office of Vocational Rehabilitation	4	1	3	14,126			
Total	94			4,528,124	56		1,014,900

Office or Bureau	Mutual Security Agency				Department of Defense Ryukyuan program	
	Number United States staff	Number staff abroad	Estimated trainee workload	Amount	Estimated trainee workload	Amount
Office of the Secretary	4	(97)	[3] (316)	$15,000	(3)	
Social Security Administration			7	17,870		
Office of Education	12	34	86	334,147	3	$6,710
Public Health Service, Division of International Health	20	63	223	488,425		
Total	36			855,442		6,710

TOTAL

Office or Bureau	Number United States staff	Number staff abroad	Estimated trainee workload	Amount
Office of the Secretary	21	(286)	(2,897)	$92,131
Social Security Administration	18	18	99	416,861
Office of Education	82	85	2,169	2,697,677
Public Health Service:				
Division of International Health	55	172	613	3,033,556
National Office of Vital Statistics	6	10	13	150,825
Office of Vocational Rehabilitation	4	1	3	14,126
Total	186			6,405,176

[1] Total of 397 through Mar. 31, 1953.
[2] Total of 1,046 through Mar. 31, 1953.
[3] Total of 255 through Mar. 31, 1953.

Mr. BUSBEY. I am frank to admit that I am not in a position to make any specific recommendations with regard to that program, but I earnestly suggest that it be studied very carefully by you, Mrs. Hobby, and that it be studied by your assistants.

Secretary HOBBY. We are already making such a study.

Mr. BUSBEY. To see if these agencies of Government could not handle that in their own departments under their own appropriations, rather than handling it through your Department with the consequent transfer of these funds to your Department.

Secretary HOBBY. We have initiated a study on that activity already, Mr. Busbey. It is going forward now.

Mr. BUSBEY. I am very pleased to hear that.

Secretary HOBBY. With relation to both to State and mutual security.

DEPARTMENTAL POLICY DEVELOPMENT AND PLANNING

Mr. BUSBEY. On page 9 you referred to "policy development and planning." It has been my observation over the years that there has been a great deal of policy development and planning in the former Federal Security Agency, but that is as far as it seems to go. By that I mean that these plans are developed but then nothing happens.

I think that it is a matter of record that a great many of the changes and reforms accomplished in the Department have been made because of congressional mandates. It is my belief that the Congress, whether it is through the Appropriations Committee or the proper legislative committee, should be spared the necessity of going into the Department and making these needed changes that are within the power of the Department to make. Frankly, I am very hopeful that under your leadership the Department will start initiating its own reforms and its own changes in the organizational setup and that in the future it will not be necessary for any congressional committee to go into the Department and bring about these reforms through congressional mandate.

While I appreciate, also, that you are new in the Department, I am very hopeful that when you come before this committee next year you will be able to tell us of the various changes you have initiated and put into effect which will have brought about a great deal of efficiency and economy in the Department.

Secretary HOBBY. We mean to make a very serious effort in that direction, Mr. Chairman.

PROPOSAL FOR INTRADEPARTMENTAL TRANSFER AUTHORITY

Mr. BUSBEY. On page 10 of your statement you state:

> It is my understanding that the other department which comes under the jurisdiction of this subcommittee, namely, the Department of Labor, has authority to make such transfers.

That is in regard to transfer of funds between appropriations within the Agency. Maybe I should thank you for calling to the committee's attention this situation in the Department of Labor appropriation act.

Secretary HOBBY. I hope I have not told you something I should not have.

Mr. BUSBEY. I, personally, have not looked too favorably upon this very free flexibility permitted in the transferring of funds from one part of a department or agency to another.

Secretary HOBBY. I would not either, sir, if it were an appreciable sum.

Mr. BUSBEY. You state further:

> The flexibility provided for this transfer provision might well enable us to conduct the management survey without asking the Congress for any special funds for that purpose.

What would such transfers amount to, and what did you have in mind as purposes for which transfers of funds would be made?

Secretary HOBBY. Mr. Stephens, can you answer that?

Mr. STEPHENS. The language which is proposed there—which you do not have; and you will get it tomorrow—is to limit it to transfers between salaries and expenses and to limit it to not to exceed 5 percent from or to any appropriation. Nobody contemplates the full and complete use of that, but there have been occasions, Mr. Chairman, in the last 2 or 3 years, where that kind of a provision, which used to be, which was once in the Federal Security language, would have saved us an awful lot of headaches, work with the General Accounting Office, trying to pay terminal leave, to get this or that project done, and so on. I know that Mr. Fogarty remembers a case where we had to come up and get $5,000 or $6,000 to do studies of Columbia and Howard. The money you had appropriated was practically all spent. We could have gotten that done had we had the privilege of assessing the units concerned for $1,000, $2,000, or $3,000 to do such studies.

I am letting you in on a little secret. When the change of administration came along and Mr. Ewing went out, with terminal leave, and Mr. Thurston went out, with terminal leave, we managed to cover that. Mr. Chairman, it was an excruciating job to pay that, when we had such a little appropriation, and we were so tied down. Most offices had to let the vacancies stand and let the work pile up to accumulate the funds. If we could have gone out to the several appropriations from Public Health, from the Food and Drug, and so on, we could have done that without seriously crippling some of the appropriations in the Office of Administrator appropriation.

I give you my word, Mr. Chairman, that it has been a mean job to find it. They come trotting in and say: "He has gone and he has got $4,000 of leave." We have to pay it under the law. What do we do? In my office, Mrs. Hobby's office, Mr. Miles' office, we just sit back and say: "You cannot fill that job, much as it is necessary. We must find this money." In a little appropriation it is a difficult task.

Mr. BUSBEY. What is that old slogan: "Where there is a will there is a way."

Mr. STEPHENS. That is what happened sir. There was a will and there was a way up to now. I do not know what would happen now, because every dime is committed.

MANAGEMENT SURVEYS

Mr. BUSBEY. What would be wrong with asking Congress for funds for a management survey if you decided you wanted to hire a firm to make one? From my experience in looking over the costs of

management surveys, particularly in the State Department and the Veterans' Administration, these surveys cost sizable amounts of money. Unfortunately, like most of the planning which has been done in the past in the former Federal Security Agency they have produced volumes of information but nothing has been done to implement the recommendations.

I hope my confidence will not be shattered a year from now, Mrs. Hobby, but, frankly, I have great confidence in your ability to pick Assistant Secretaries and heads of departments who should be able and capable of knowing their agencies better than anyone else and who can implement the recommendations of their own surveys.

Secretary HOBBY. I would much rather have the authority, Mr. Chairman, to make small transfers of funds. If I would not burden the committee, in my own business experience with outside managemen surveys I have found that if you get a complete management survey at one time it is, to use the vernacular, a very big bite out of the manpower in your own organization. The plan I have followed in my own business is to not tackle a big thing at one time, but to tackle related things until it makes a picture. If you make an entire management survey of the Department of Health, Education, and Welfare, I would hesitate to hazard a guess as to what it would really cost. I think it would cost a very great sum of money. But I believe if we could do it slowly, where we find weaknesses in management, with even small transfers of funds, bringing in consultants on special projects when they are needed, we could do it better than if we had a great sum of money for an outside management survey to do it. It is so big if you take it all at once.

I am certainly finding now how many hours in manpower it takes out of your day-to-day operations to make even limited organizational changes. It is a sort of a crippling kind of thing. I think it is too big and too diversified to tackle as one big management problem. I think social security almost has to be approached on its own. The Office of Education almost has to be approached on its own. I would rather do it that way and then let the top management staff over there pull the things together in one big administrative plan. I think it would cost less and I believe it would be more satisfactory.

REVIEW OF FEDERAL GRANT-IN-AID PROGRAMS

Mr. BUSBEY. Do you have any information with regard to the President's plan to have all of these Federal grant-in-aid programs reviewed?

Secretary HOBBY. Well, I will tell you all I know about it. As you know, the legislation is up here now. We have been asked to accumulate a list of specific problems which arise and occur, and turn the list of problems over to the President's Commission.

Mr. BUSBEY. Of course, I appreciate the fact that a great many Members of Congress do not agree with my thinking on a great many things, but at the same time it is still my honest conviction that in the past years we have had too much thinking in policymaking levels of:

"What programs can we get into to promote and spend some money?" rather than: "What programs can we eliminate and save some money?" or "What can we do to bring about efficiency and economy in Government?"

STATE ASSUMPTION OF RESPONSIBILITY

There is not any secret about where I stand on these things, because I have told the various agencies which have appeared before this committee that fundamentally I am in favor of the States assuming a greater responsibility. I was glad to see in your prepared statement that you mentioned the fact that they seem to be in a much better financial condition to do it, generally speaking, because I think that this centralization of government here in Washington, with the people and the various States continuously looking to the Federal Government for bigger and better handouts has got to be stopped or it is going to be the ruination of our republic. I feel very strongly on that. It has been consistent with me ever since I have had the privilege of serving in Congress. It is going to be so long as I have that privilege.

I may be a voice crying in the wilderness to a great extent, but I am still going to make the fight.

Secretary HOBBY. You would make a very good witness for the President's Commission, Mr. Busbey.

PROPOSED LANGUAGE AUTHORIZING TRANSFERS FOR REGIONAL OFFICE ACTIVITIES

Mr. BUSBEY. You have this new language on page 245 of the committee print:

Provided, that the Administrator—

now the Secretary—

may advance to this appropriation from appropriations of constituent organizations of the Federal Security Agency such sums as may be necessary to finance the regional office activities of such constituent organizations.

Mr. Ewing, the former Administrator of the Federal Security Agency, was a great one for wishing to transfer funds from one agency to another. This committee has never looked too favorably on it, Mrs. Hobby.

It is not that I personally would oppose it, necessarily, but I am certainly going to have to be convinced that it is a desirable thing. That is not because it is the Department of Health, Education, and Welfare, because I feel that way with respect to any department of government. It is just fundamental with me.

Mr. STEPHENS. Mr. Chairman, may I speak to that language, sir?

Mr. BUSBEY. Yes.

Mr. STEPHENS. That was designed by the Budget Officer of the Federal Security Agency on a technical basis. We have in each region a little fiscal office which pays people their travel and salaries and supplies, for some 25 or 30 appropriations. That was designed to put the money from Public Assistance, the Children's Bureau, the OVR, and so forth, all in one pot, so that this little staff out there could pay everybody out of one bank and on one payroll, without taking anything away from the units themselves. In other words, Public Assistance, OVR, Education and Public Health units would continue to justify the money they need for their field operations in the regional offices, and would talk to you about it, and would get the necessary money from the committee and the Congress to do that, but once it is gotten, since it is clearly set out in the budget as to the number of people in the field and how they must meet their costs, that money

could be put in one pot and we would simplify this to a great extent not only in the work of the agencies of the Department in the regions but the work of the General Accounting Office and the Treasury Department. The accounts current now prepared on these things in the regional offices, where there is a very small and a very low staff, make a stupendous undertaking to keep up with it.

The most recent case would be very simple. If the pay clerk in the New York office paid 175, 200, or 500 people from 1 pot, instead of from 20 or 25 pots, the work in the field would be so simplified that it would be far simpler. I do not mean that we would be able to eliminate a lot of jobs, but the amount of overtime and paperwork which is going on between us and Treasury would be far simpler, without detracting one bit from the work of the units. They would still justify it, the same as they always have.

STAGES IN BUDGET REVISION

Mr. FOGARTY. Mrs. Hobby, you are presenting to us now the revised budget for your Department for 1954.

Secretary HOBBY. Yes, sir.

Mr. FOGARTY. Could you develop for the committee the steps which have been taken, since you have been Administrator and now Secretary, in developing these new figures?

Secretary HOBBY. First, Mr. Fogarty, we went over the budget ourselves. Then we had the head of the constituent agency and the budget officer in, on the theory that they certainly knew better than I where cuts could be made which would do the least damage to the program. That was the procedure we followed right straight through.

Mr. FOGARTY. You had this meeting with the heads of the various agencies and you came up with a revised figure?

Secretary HOBBY. Yes, sir.

Mr. FOGARTY. That was then sent to the Bureau of the Budget?

Secretary HOBBY. Yes, sir.

Mr. FOGARTY. Is that the budget that the Bureau approved?

Secretary HOBBY. No. There was some negotiation then between the Bureau of the Budget and my office, sir.

Mr. FOGARTY. In other words, they did not take your first estimate?

Secretary HOBBY. No.

Mr. FOGARTY. So then you had to sit down and go over the whole thing again?

Secretary HOBBY. Yes.

Mr. FOGARTY. Did they accept your latest revised figures?

Secretary HOBBY. Well, there was negotiation back and forth, Mr. Fogarty, on different items. It was never all at any one sitting.

Mr. FOGARTY. So, in other words, they did not accept your revised figures the second time, either?

Secretary HOBBY. Well, I acceded to some and they acceded to some.

EFFECT OF EXPRESSED VIEWS OF CONGRESS

Mr. FOGARTY. When you are making up a budget like this do you take into consideration the action of Congress in the past?

Secretary HOBBY. I am not sure I know how to answer that. I do not know exactly what you mean.

Mr. FOGARTY. I mean this: Take, for instance, payments to school districts. Budgets for this item have been cut by the Appropriations Committee in the past, but every time the cut has been corrected on the floor by a tremendous majority, which shows that the will of Congress is to pay these entitlements to these school districts. That is one example of what I mean.

Secretary HOBBY. Yes. Would you like to speak to that, Mr. Miles?

Mr. MILES. Yes. Mr. Fogarty, I think it can be said that we undertook to balance insofar as possible the considerations of the kind of which you speak and the necessity for making as firm movements toward economy as possible. In other words, we were not unmindful of the facts you mention.

Mr. FOGARTY. What is the thinking of the Bureau of the Budget with respect to the expressed will of Congress?

Mr. MILES. I am afraid I could not interpret the mind of the Bureau of the Budget.

Mr. FOGARTY. You worked in the Bureau of the Budget at one time.

Mr. MILES. Yes, sir; I did, for quite a number of years, but I would not undertake to interpret at the present time the mind of the Bureau of the Budget.

PAYMENTS TO SCHOOL DISTRICTS

Mr. STEPHENS. Mr. Fogarty, on that item, this particular item you will remember we had $40 million in 1953, and we came up for $24 million more, and Congress made it $20.5 million. That made $60.5 million for this year. Now, when we went up to $70 million, that was a sizable increase, about a 15 or 20 percent increase. When they cut it back to $66.5 million—anticipating and seeing all of the factors, including the action of Congress, that was a 10-percent increase over the current fiscal year, which I believe takes into consideration action of the Congress.

Mr. FOGARTY. You know, Mr. Stephens, it would not have made any difference whether that was $20 or $40 million that day on the House floor. It still would have received the same majority, which was 200 some to 18 or 20. There were only 18 or 20 votes against it in the House.

I remember trying to justify a cut on this appropriation in 1951, the first one that was made, and I did not have my heart in it, to be honest with you. We were just swamped on the floor. We did not even ask for a record vote or a standing vote on it.

I am thinking along the same line with respect to the other items here. George-Barden funds, for example, have been cut 25 percent. Do you think Congress is going to go for that? It looks to me as though either the Department or the Bureau of the Budget is saying to Congress: "Now you have been doing a lot of talking about balancing the budget. We are going to send up a set of figures and let us see you do with it what you will."

That is the way it looks to me. I think that this is a pretty drastic budget which you have sent up to us, especially so far as the Public Health Service is concerned.

DELAY IN OPENING OF CLINICAL CENTER

Another thing I am very much disappointed in—and I think it is the fault of the Bureau of the Budget—is the opening of the new Clinical Center at Bethesda. Because of the order by the Budget Director this opening is being set back about 4 months, as I figure it.

You say in your statement that it will start taking patients on July 1. I do not know how they are going to start on July 1. Do you?

Mr. MILES. I am not sure I understand why they cannot, Mr. Fogarty.

Mr. FOGARTY. They told us that it would take them at least 60 days to open from the time they are allowed to start hiring personnel and that they wouldn't be allowed to do that until a definite determination is made on the 1954 amounts which means action by the Congress. The center was scheduled to open in April of this year. Congress, I think, expected it to open. I know this committee expected it to open. Because of a directive issued by the Bureau of the Budget the opening is being postponed, according to your statement at least until July 1.

Mr. MILES. If 1953 funds are released and approval is given to open on the 1st of July——

Mr. FOGARTY. That release has not been given yet, has it?

Mr. MILES. I am not sure whether it formally has been given, but it certainly is now understood that it will be given, if it has not actually been given in writing.

BED OCCUPANCY PLANS FOR 1954

Mr. FOGARTY. Why have you decided you would only have 250 beds occupied by the end of next fiscal year, when we have room for 500?

Mr. MILES. That, Mr. Fogarty, is another one of these difficult balancing decisions of economy versus the desire to move ahead with a program. Certainly as a clinical center of that magnitude is opened it can be maintained that you will get greater efficiency and economy if you move up gradually rather than trying to move up too rapidly toward the complete filling of it. That was one of the elements which was involved.

Mr. FOGARTY. Do you think that after we have spent about $60 million in building that center there is any economy by holding off using it?

Secretary HOBBY. I do not think it could have been opened April 1, Mr. Fogarty.

Mr. FOGARTY. No. They were delayed about a month, I think they said. They said they could have opened late in April or the first of May.

Secretary HOBBY. I went out there the other day to look at all the laboratory rooms. I think there is only one elevator which has been turned over by the contractor to the Public Health Service. On the floor where I was looking, the three-corridor one, which you no doubt are familiar with, the laboratory rooms still do not have any partitions. There is still a great deal of work to do. It has just been roofed in. I do not know how quickly that can be done. There was not a finished laboratory room on that floor. My understanding is that the

laboratories closest to the hospital rooms will be completed about June 1. Other laboratories will not be completed for several months.

I was there yesterday a week ago, I believe. There is still a great deal of work to be done.

Mr. FOGARTY. This hospital, as you know, was conceived, or the first appropriation made, in 1947.

Mr. STEPHENS. Fiscal 1948.

Mr. FOGARTY. Yes, the calendar year 1947. As you remember at that time also there was great need for economy, and this Congress went ahead with this new project and appropriated money to build this project. We thought we were going to have it open in April, but it is impossible to do it, as a result of what the Bureau of the Budget has done.

Now, I just do not like that kind of action on the part of the Bureau of the Budget. The Bureau of the Budget is supposed to make recommendations to the Congress. We make the appropriations and we determine what these appropriations are to be used for. Apparently there are many people in Government who think that the only thing they can do is follow the dictates of the Bureau of the Budget.

I know you have had a division of opinion in the Bureau of the Budget on how much money should be spent on research. There has always been that division in the views of the various teams at the Budget Bureau. I think that we should insist that this be put into full operation when we take action on this appropriation, and not permit the opening to be delayed.

BASES FOR BUDGET CUTS IN CATEGORICAL HEALTH GRANT PROGRAMS

Now, Mrs. Hobby, you said in your opening statement that you were going to cut every cent not producing results, and avoid waste and duplication and inadequate management. Where these cuts in the categorical programs in Public Health were made, was that because some of these programs were not producing results or because there was a lot of waste or inadequate management in any of these programs?

Secretary HOBBY. No, sir; I do not think that was the determining factor. We were trying to cut, as you know. In going through this with Public Health and trying to find where we could cut to hurt the least, these were the things we came up with.

Mr. FOGARTY. How do you make a decision, let us say, as to whether or not a cut in a State grant program is going to hurt, help, or do a lot of harm?

Secretary HOBBY. Well, it is very difficult to do, as you well know, sir. You have to play by ear a lot.

Mr. FOGARTY. I presume that many of these cuts are made in State grant programs.

Secretary HOBBY. Yes.

Mr. FOGARTY. Did I not also hear you say, or hear that the Bureau of the Budget said, that it was not going to cut some appropriation of the Office of Education because the various legislatures throughout the country have finished their business and will not reconvene until 1955? Was that in your statement?

Secretary HOBBY. It was in the Bureau of the Budget letter I read.

Mr. FOGARTY. Why should that not pertain to these public health programs, the grant-in-aid programs?

Secretary HOBBY. Well, that is a difficult question to answer, Mr. Fogarty.

Mr. FOGARTY. I think that it is very unfair to say to a State, which has made plans based on past appropriations for these categorical programs, especially in public health, that on the 1st of July or some time in June "You are going to be cut 25 percent," or 40 percent or 50 percent, when its legislature has already met and will not reconvene for another year or two.

Was there any investigation of the situation in the States to determine whether or not they would carry on these programs if the Federal Government did not provide the money?

Mr. BUSBEY. Will the gentleman yield there?

Mr. FOGARTY. Yes.

STATE ASSUMPTION OF RESPONSIBILITY

Mr. BUSBEY. Was there any guaranty to the States that these appropriations will be continued at the same or an increased level year after year?

Mr. FOGARTY. There is no guaranty, Mr. Chairman, but when we have programs which have been operating for several years the States make their plans based on past actions of the Congress. Unless they have been given some good reason to change their own plans they just go along on that basis.

Mr. BUSBEY. Well, that gets back to my old point. I do not think the States have any right whatever to rely on the Congress to appropriate this money until it is already appropriated. They come in every year with that argument. It just does not hold water, so far as I am concerned.

Mr. FOGARTY. That is where you and I disagree, Mr. Chairman. Your argument would not hold true so far as the Federal Government participating in these public health programs is concerned. I am confident that if the Federal Government did not take the lead in some of these public health programs the people would suffer, and not the Federal Government or the States. If we had left it up to the States, they just would not proceed with some of these programs which have helped the people and helped all people. It does not make any difference whether you are from California or Texas, or where you are from. These public health programs, I think have helped every person living today.

Mr. BUSBEY. But do you not think that the States ought to assume the responsibility of their continued operation after they have been initiated by the Federal Government?

Mr. FOGARTY. I think they should, and I think they have in many cases. I think they have in tuberculosis and venereal diseases. But if it had not been for the leadership of the Federal Government I am sure—and I think you are—that there would be many people 6 feet under who are living at the present time.

Mr. BUSBEY. No one can deny that, but at the same time just because the Federal Government initiates a program is no guaranty that it is going to continue it year after year. The States should assume their responsibilities. Pardon me for interrupting.

Mr. FOGARTY. I agree with you. After all, it will be Congress which will make the decision on these appropriations, anyway, as it always has. But I think in order to be fair about it, if we want to be fair about it, if there is going to be a change in policy so far as the State grants are concerned I think that change should be recommended to the Congress and to the appropriate legislative committee, and these changes should then be advocated in the basic law. I do not believe that we should legislate on appropriation bills. I never have. I do not believe in it. I think that is the easy way out. I think we are avoiding our own responsibility by doing it this way.

EXTENT OF REDUCTION FOR PUBLIC HEALTH SERVICE

Now, we have a revised budget before us which shows some pretty drastic changes. What is the overall percentage cut in the Public Health Service?

Mr. STEPHENS. I do not have the percentage, Mr. Fogarty; I have the figures.

Mr. FOGARTY. Well, it would not take you long to get the percentage.

Mr. STEPHENS. No, sir. The original estimate was $270,893,000; the present revised budget is $219,665,000. Dividing the $51,228,000 into the $270 million gives about an 18 percent cut, roughly, or 19 percent.

Mr. MILES. Nineteen percent.

Mr. FOGARTY. So the Public Health Service is taking a 19-percent reduction in this revised appropriation request. That is greater than that in any other agency in this bill.

Mr. STEPHENS. Mr. Fogarty, there is an item of $15 million in there for research construction grants which has been taken out by the committee and by Congress. Deducting that from the $51 million leaves an actual cut of $36 million.

Mr. FOGARTY. That was in the overall figure; was it not?

Mr. STEPHENS. It was in the overall figure. Taking it out both ways, the percentage would be somewhat smaller.

REVISED ESTIMATE FOR PAYMENTS TO SCHOOL DISTRICTS

Mr. FOGARTY. Now, on the payments to school districts, you are just making a guess in that 5-percent reduction; is that right?

Mr. STEPHENS. Yes, sir; that is right. And in the original justifications, Mr. Fogarty, if you remember, there are about 5 or 6 sections in the school district item, and in the justifications themselves the Office of Education made their original comments on each section. Practically all the way through there is a 5-percent item for increased cost which we do not believe now will occur. Taking just that factor, you come up with about a 5-percent reduction, which still leaves a 10-percent increase over the current fiscal year.

Mr. FOGARTY. But if those increases do occur, you are coming back with a supplemental bill?

Mr. STEPHENS. We might or might not, depending on the decreased spending.

Mr. FOGARTY. If, according to the law they are eligible for additional payments, Congress will make the payments unless the law is changed.

Mr. STEPHENS. Unless the payments are cut——

Mr. FOGARTY. Well, Congress has not allowed that in the past.

Mr. STEPHENS. Well, in this particular item, $66.5 million, I believe just common, cold-blooded logic, as we have to apply in my office, would indicate, except for the Bridges amendment, there are no factors in 1954 that were not applicable in 1953, and in 1953 we are getting by without the Bridges amendment for $60.5 million. We added 10 percent. There will be less than a million dollars because of the Bridges amendment, which would have made it $61.5 million. That would still give a $5 million increase over the current fiscal year.

Mr. FOGARTY. There have been bills introduced to extend this act?

Mr. STEPHENS. That is right.

ESTIMATED COST OF PROPOSED LEGISLATION EXTENDING SCHOOL CONSTRUCTION ACT

Mr. FOGARTY. And the School Construction Act, also?

Mr. STEPHENS. That is right.

Mr. FOGARTY. Did the bill that was proposed to amend the School Construction Act carry any estimated cost figure?

Mr. MILES. The estimated figure, Mr. Fogarty, is very substantially below what the previous bill would be. It would come to about $140 million over a 2-year period or an estimate of about $100 million in the first year—that is, $100 million in 1954.

Mr. FOGARTY. The estimate, of course, will be based upon conditions now and no one can foresee the conditions 2 years from now.

Mr. MILES. The draft bill has been modified as compared with the earlier law so as to put no obligation on the Congress to make any additional appropriations beyond what were authorized in the first instance. In other words, no supplemental of the kind Mr. Busbey was referring to would be necessary.

ESTIMATED COST OF PROPOSED AMENDMENT EXTENDING PUBLIC LAW 874

Mr. FOGARTY. I see. Now, the changes in Public Law 874, you say, if enacted into law, would save us about $15 million. Those changes are changes in the formula of allotment?

Mr. MILES. Yes.

Mr. FOGARTY. Are they the same changes that were recommended a year ago and on which the committee took no action?

Mr. MILES. Some of them are.

Mr. FOGARTY. I remember that figure. They said it would probably save $15 million if those amendments had been put into effect.

SALARIES AND EXPENSES OF OFFICE OF EDUCATION

Now, in the Office of Education, Mrs. Hobby, you say that you have been allowed about $92,000 for 1954 by the Budget Bureau under Public Law 550.

Secretary HOBBY. That is the figure I remember. That figure sticks in my mind.

Mr. STEPHENS. It is something under $100,000.

Mr. FOGARTY. As I understand the situation in the Office of Education, because Congress refused to give them some $200,000 for

the carrying out of these programs, they had to lay off 41 employees they had working on this program, plus an additional 25 employees, plus a furlough for everyone in the Office. Is that a correct statement?

Mr. MILES. I think so, Mr. Fogarty. I will double check, but that is in accordance with my recollection.

Mr. FOGARTY. The Bureau of the Budget has recommended some $200,000 for the rest of this fiscal year.

Mr. MILES. You say they have recommended that?

Mr. FOGARTY. That is what we were told by the Office of Education.

SUPPLEMENTAL ESTIMATE FOR 1953

Mr. STEPHENS. No, sir. There is a supplemental in process. The fact of the business is it is now in the Bureau of the Budget, and it is for considerably less than the original amount. They wrote us a letter. The fact of the business is the letter went to Mr. Bridges. Mr. Bridges asked the Bureau of the Budget at the time this supplemental was in process—in fact, it was on the floor—and the Director of the Budget's letter reached him after final action on the floor of the Senate; so, no action was taken. We then submitted to the Bureau of the Budget another request for an additional supplemental, because of this furlough and the predicament we had gotten in on the unequal apportionment in the Office of Education and the item in OASI. But that is still in the hands of the Bureau of the Budget. I do not think they have made a final decision whether to submit it to Congress or just to ride it out.

Mr. MILES. The situation there, Mr. Fogarty, is that the Director of the Bureau of the Budget wrote us saying that if the Congress were to indicate its desire to consider a supplemental for this purpose they would be glad to forward such a request to the Congress, but in the absence of such indication by either House of Congress they were reluctant to forward the estimate.

Mr. FOGARTY. I thought that the Office of Education officials testified that the Director of the Budget did send a request to the chairman of the Appropriations Committee of the Senate requesting the sum of $200,000. Do you recall that? I am pretty sure they did.

Mr. BUSBEY. I might say no letter of any kind has come to the attention of the chairman of this committee.

Mr. FOGARTY. I was referring to the chairman of the Senate Appropriations Committee.

FURLOUGHS WITHOUT PAY

It is unthinkable to me that Congress or your Department or the Bureau of the Budget would force Federal employees to take furloughs without pay. It is just unthinkable to me that anyone would force any employee to take a vacation without pay in order to keep within his budget.

Mr. MILES. Mr. Fogarty, if I may comment on that, if an agency found itself in a position where it was necessary to consider two alternatives, either laying off people who might eventually be reemployed or having a temporary furlough, and if the employees of the organization indicated they would prefer to have a furlough rather than have a smaller group of the employees laid off, does not it seem that that alternative of a furlough might be the more acceptable one of the two?

Mr. FOGARTY. Not to me it would not. I think that it is one of the worst things that can be done. I do not care whether it is in the Federal Government or in private employment. Those are the tactics that have been used in private business in the past to get people to accept a lower wage. You know that as well as I do. But here we are spending billions of dollars, and in a small office like this we are forcing them to take a vacation without pay rather than give them the funds to do the work that Congress has asked them to do. I do not see how the Department, the Bureau of the Budget, or Congress can justify that. I do not see how anybody can justify taking a position similar to that. If the work is to be done, then it is up to Congress to provide the money, or else we ought to repeal the basic legislation.

And I think that the Bureau of the Budget, if its officials do not believe in certain programs, should recommend to the Congress and to the appropriate legislative committees to repeal that particular legislation or that particular program, rather than just to cut the money for the program.

How do you feel about it?

Mr. MILES. Well, sir, I regret very much the necessity of even considering a furlough, and it is only because of the very difficult situation in which we find ourselves as a result of the lack of funds that it is necessary.

CONGRESSIONAL ACTION ON 1958 SUPPLEMENTAL REQUEST

Mr. FOGARTY. I appreciate the fact that that situation is not the fault of the Department. I think basically that it is the fault of Congress. I believe—and I said this before—that if the Congress passes a law in the last days of its session, and the Bureau of the Budget gives the agency that has work under that law the authority to go ahead and hire personnel to do the work, then they have every right to expect a supplemental appropriation from Congress. I do not put the blame on your Department or the Bureau of the Budget. I think it is the fault of Congress. And I know the legislative committee that enacted Public Law 550 agrees with what I am saying at the present time. They feel that this arrangement was made in good faith and that the supplemental should not have been refused. However, Congress itself did not see fit to go along with it, and your Department cannot be blamed for that. But if you had a provision allowing you to transfer 5 percent, you probably could have taken care of this situation. Could you not? There will be money unspent in the Office of Education under other appropriations, will there not?

Mr. STEPHENS. Legally we might have done that, but in the face of adverse action by Congress we would have hesitated to circumvent the will of Congress and made the transfer in spite of the action of Congress.

Mr. FOGARTY. But you might have done that before the request was made to Congress.

Mr. STEPHENS. Yes. They could have transferred money from other activities and perhaps saved the request for a supplemental.

EFFECT OF PROPOSED REDUCTION FOR HOSPITAL CONSTRUCTION PROGRAM

Mr. FOGARTY. I notice that you are cutting the hospital-construction program by $15 million—from $75 million to $60 million.

Secretary HOBBY. Yes, sir.

Mr. FOGARTY. The basic law authorizes the expenditure of $150 million a year under the Hill-Burton Act. One year the Congress did let you spend $150 million, a couple of years ago $82 million was appropriated, and this year $75 million was approved.

How many communities which have already raised funds through bonds, and by whatever other means they could, will be prevented from building their hospitals if this $15-million cut is put into effect?

Secretary HOBBY. We have a breakdown on that, Mr. Fogarty, which we would be glad to supply.

Mr. FOGARTY. Will you show the hospital projects and the communities and the States they are in?

Mr. STEPHENS. Yes, sir.

Mr. FOGARTY. How will this cut affect the 2-year program or the split projects?

Secretary HOBBY. Mr. Stephens can give you the actual number.

Mr. MILES. I thought it was seven projects.

Secretary HOBBY. Projects in 7 or 8 States would be affected.

Mr. FOGARTY. Will you get the number of projects, the names of the projects, and how it will affect all of them?

Mr. STEPHENS. Yes, sir.

(The information is as follows:)

States receiving insufficient funds, under an appropriation of $60,000,000, to cover split projects in fiscal year 1954

ARKANSAS

1954 allotment to the State on basis of $60,000,000	$1,322,676
1954 funds earmarked for split projects	1,646,136
Difference	323,460
Projects and 1954 Federal share:	
Little Rock:	
University of Arkansas Medical Center	599,000
St. Vincent Infirmary	977,136
Fort Smith, St. Edwards Mercy	50,000

GEORGIA

1954 allotment to the State on basis of $60,000,000	2,172,443
1954 funds earmarked for split projects	2,212,923
Difference	40,480
Projects and 1954 Federal share:	
Covington, Newton County	114,816
Ellijay, Watkins Memorial	52,967
Marietta, Kennestone	157,500
Brunswick, Glynn County H. C	26,167
Statesboro, Bulloch County	126,000
Bremen, Bremen	53,000
Columbus, Muscogee County H. C	70,892
Macon, Macon City	846,170
Savannah, Memorial Hospital	753,830
Oglethorpe, Macon County H. C	11,581

States receiving insufficient funds, under an appropriation of $60,000,000, to cover split projects in fiscal year 1954—Continued

KENTUCKY

1954 allotment to the State on basis of $60,000,000	$1, 855, 945
1954 funds earmarked for split projects	2, 066, 514
Difference	210, 569
Projects and 1954 Federal share:	
Lexington, Good Samaritan Hospital	150, 000
Ashland, Kings Daughters	33, 333
Danville, Ephraim McDowell Memorial	83, 581
Georgetown, John Graves Ford Memorial	101, 250
Bellefonte, Bellefonte	254, 546
Fort Thomas, Campbell County General	407, 825
Elizabethtown, Hardin County	176, 548
Paducah, Riverside Hospital	153, 097
Shelbyville, Shelby County	178, 312
Louisville, Jewish Hospital	428, 022
Bowling Green, Bowling Green-Warren County	100, 000

NEW JERSEY

1954 allotment to the State on basis of $60,000,000	1, 185, 653
1954 funds earmarked for split projects	1, 538, 606
Difference	352, 953
Projects and 1954 Federal share:	
Mount Holly, Burlington County	23, 696
Cedar Grove, Overbrook	70, 000
Plainfield, Muhlenburg	193, 850
Paterson, St. Josephs	38, 731
Hackensack, Hackensack Hospital	250, 680
Trenton, St. Francis Hospital	511, 150
Summit, Overlook	285, 499
Ancora, Fourth State Mental	165, 000

OHIO

1954 allotment to the State on basis of $60,000,000	2, 306, 027
1954 funds earmarked for split projects	2, 486, 176
Difference	180, 149
Projects and 1954 Federal share:	
Barberton, Barberton Citizens	129, 781
Akron, Peoples	411, 361
Warren, Trumbull Memorial	250, 000
Youngstown, St. Elizabeth	492, 000
Warren, St. Josephs Riverside	100, 000
Bay Village, Bay View	20, 357
East Liverpool, East Liverpool City	200, 000
Cleveland, Fairview Park	250, 000
Marion, Marion	400, 000
Youngstown, Youngstown	232, 677

RHODE ISLAND

1954 allotment to the State on basis of $60,000,000	247, 602
1954 funds earmarked for split projects	319, 776
Difference	72, 174
Projects and 1954 Federal share:	
Pawtucket, The Memorial	5, 000
Cranston, Osteopathic General	55, 000
Providence, Miriam	126, 601
Providence, Roger Williams General	133, 175

States receiving insufficient funds, under an appropriation of $60,000,000, to cover split projects in fiscal year 1954—Continued

SOUTH CAROLINA

1954 allotment to the State on basis of $60,000,000	$1, 458, 276
1954 funds earmarked for split projects	1, 800, 000
Difference	341, 724
Project and 1954 Federal share:	
Charleston, Medical College of State of South Carolina	1, 800, 000

HOSPITALS AND MEDICAL CARE

Mr. FOGARTY. You are cutting the direct medical care program by $1.7 million. You say that you will have to close three hospitals. What hospitals will be closed?

Secretary HOBBY. One of them, I believe, was Fort Stanton, and there is a question of whether it would be Detroit or Cleveland.

Mr. STEPHENS. Cleveland was under consideration. And then it is a choice between Savannah and Memphis.

REIMBURSABLE PATIENT LOAD FROM VETERANS' ADMINISTRATION

Mr. FOGARTY. You say that the reimbursable patients of the Veterans' Administration are decreasing in number?

Secretary HOBBY. Yes, sir.

Mr. FOGARTY. That will mean another cut in addition to this one?

Mr. STEPHENS. That cut is taken into consideration.

COST OF CONTRACTING FOR CARE OF FEDERAL EMPLOYEES

Mr. FOGARTY. At the same time you probably will have to contract some of these services you are giving now for some Federal employees?

Secretary HOBBY. Public Health will.

Mr. FOGARTY. Do you know how much that will cost?

Mr. STEPHENS. I do not have that figure. But that is being done all the while. Occasionally a Federal employee is injured in line of duty some place and, if he was in some city like Chattanooga, where he was too far from a marine hospital, he would, as a matter of fact, be contracted to some private hospital. And if he was in the vicinity of a marine hospital, he would be treated in the Public Health Service hospital.

The closing of three hospitals would mean possibly some of those Government employees injured in line of duty would have to get their hospitalization by contract instead of in a marine hospital. That policy works now in some sections where it is not feasible or economical to take them to a Public Health Service hospital. There would be an additional number of those who would be contracted for.

PROBLEM OF AGING POPULATION

Mr. FOGARTY. Mrs. Hobby, has anything been accomplished in regard to the problem of aging?

Secretary HOBBY. I cannot give you anything definite. As you know, we have a small study going on right now.

Mr. FOGARTY. I know. It is a very big problem, too.

Secretary HOBBY. It certainly is, and we have just agreed to participate in this conference which has just been called on the problem of aging.

CIVIL SERVICE MAXIMUM AGE REQUIREMENTS

Mr. FOGARTY. Is there some requirement of Civil Service that you cannot employ a person in a Federal job if he or she is beyond a certain age—55 or 60?

Mr. MILES. There are a number of different requirements in respect to specific jobs under civil service. Many of them set a minimum employment age of 60. And, of course, as you know, there is a requirement that all employees must retire at age 70 unless specifically exempted by the President.

EMPLOYMENT FOR OLDER PERSONS

Mr. FOGARTY. Mrs. Hobby, I do not know whether this is a fair question. I think it is, but if you do not think so, do not answer it.

Suppose you were going to hire some new people in your office—assistant secretaries or special assistants—and you found a person well qualified and just the man you wanted, but he happened to be 67 years old. Would you think although he had all of the qualifications and was in good physical condition, that he should not be hired because he was 67 years old?

Mrs. HOBBY. Mr. Fogarty, in my own business I have several men past 67 in key positions in my organization.

Mr. FOGARTY. I know older persons have a real problem in getting employment..

Secretary HOBBY. I know they do.

Mr. FOGARTY. In some places, anybody over 50 is considered to be an old man.

Secretary HOBBY. It is less than 50 now. It is beginning at 42. When you look at the scale of pensions and everything, it goes up after 42. It is a very real problem in this country, and we have to face it with some very straight thinking.

Mr. FOGARTY. Yes. With the average age increasing every year, it is a real problem.

Mr. MILES. Mr. Tibbitts, who is our man in charge of that activity, is down in the waiting room, and when you get to the appropriation "Office of the Secretary" in detail, he is available to answer further questions.

Secretary HOBBY. I consider that one of the most important functions of this Agency is to try to develop some real thinking and some real recommendations as to people of that age.

EFFECTS OF BUDGET REDUCTIONS IN PUBLIC HEALTH PROGRAMS

Mr. FOGARTY. Who is going to tell us what these budget reductions mean?

Secretary HOBBY. Anyone you wish to call.

Mr. MILES. In the Public Health Service, you may wish to have a session at which the Public Health people are present and the Surgeon General is available.

Mr. FOGARTY. I think we will have to.

You say you are reducing the request for control of venereal disease $1.6 million. I think we ought to know exactly where these cuts are, what the effect is on the programs, and whether or not the States are going to carry on.

Mr. MILES. We will be glad to arrange to have whatever witnesses are necessary to provide you with the information you would like.

Mr. FOGARTY. It was only a couple of years ago that Congress passed, by unanimous vote, a bill establishing 2 new institutes, 1 in neurology and blindness and the other in arthritis and metabolic diseases, and yet the biggest cuts you made in this revised budget come in those 2 new activities. They are only small activities; yet 2 of the largest cuts that were made were made in those 2 new institutes that we established by unanimous vote of Congress, and their activities affect millions of people.

Mr. STEPHENS. May I just quote some figures on that? Although that is a reduction from the original 1954 estimate, in both cases there is a sizable increase over the currently available amount of funds to those institutes.

Mr. FOGARTY. I know that. It was only last year that we gave them their first appropriation; was it not?

Mr. STEPHENS. That is right.

Mr. FOGARTY. So that argument does not hold much water. We had just established the institutes.

Mr. STEPHENS. Although you just set up the institutes, there were activities that were carried in our aid grants along these lines. That is how we get these comparable figures. In neurology we had $1.9 million, and this year we get $2.5 million. In arthritis it was $4.5 million, and now it is $4.9. And those figures in 1953 represent what the Public Health Service tells me were the actual moneys spent in 1953 in those specific activities.

EFFECT OF REDUCING GRANTS FOR TEACHING OF MEDICAL SUBJECTS

Mr FOGARTY. Have any cuts been made in grants to medical schools for teaching in heart, cancer, and mental health?

Mr. MILES. Yes, Mr. Fogarty; a 30-percent cut has been made.

Mr. FOGARTY. In the teaching grants?

Mr. MILES. In the teaching grants; yes, sir.

Mr. FOGARTY. How is that going to affect the programs in the medical schools?

Mr. MILES. Well, sir, the basis on which the cut was made was the medical school budgets as tabulated by figures which are available in the Public Health Service, and to the Bureau of the Budget indicating that there has been a substantial increase in the funds available to medical schools from all sources, State and private funds, tuition, and so forth, over the past several years. And in the light of that increase, it seemed that a reduction of approximately 30 percent could be made without too seriously affecting the programs.

Mr. FOGARTY. Actually, you do not know how seriously it will affect the program; do you?

Mr. MILES. Actually, we do not.

Mr. FOGARTY. You have not heard from the individual medical schools?

Mr. MILES. No, sir.

Mr. FOGARTY. You never took the time to ask them, "How will this affect your program if it is cut 30 percent or if our cancer or heart grant is taken away from you?"

Mr. MILES. There has not been time.

Mr. FOGARTY. You did not make any of those determinations at all; did you?

Mr. MILES. No, sir.

BUDGET BUREAU FREEZE ON CONSTRUCTION PROJECTS

Mr. FOGARTY. Now, in the case of a building, say, at Howard or any other Federal institution, the Congress in order to authorize its construction generally holds hearings before the legislative committee and then Congress votes on that particular piece of legislation and says it is needed. Then the Bureau of the Budget frequently comes along and says "No. Congress is wrong." That is what you are telling Congress; is it not—that Congress made a mistake?

Mr. MILES. In respect to which particular item?

Mr. FOGARTY. In the construction of some building that has been authorized by a previous Congress.

Mr. MILES. I am not sure I understand just what you refer to.

Mr. FOGARTY. Take, for instance, a building program developed for Howard University. After a hearing by a Congressional Committee Howard is authorized to go ahead and build that building, and then someone in the Bureau of the Budget comes along and says "No. We think Congress made a mistake."

Mr. BUSBEY. Will the gentleman yield right there briefly?

Mr. FOGARTY. Yes.

Mr. BUSBEY. If I follow Mr. Fogarty's reasoning on this, I do not see any necessity for an Appropriations Committee at all. If that were the case, the legislative committees would make the appropriations when they make the authorizations. I always have taken the stand and still take the stand that the authorization by a legislative committee is not a mandate to the Appropriations Committee to appropriate that money.

Mr. FOGARTY. It is not. I never said it was.

Mr. BUSBEY. I was just trying to follow your reasoning there.

Mr. FOGARTY. But some of those buildings that were authorized or those programs that were developed over a period of years for, say, St. Elizabeths, Howard University, or Freedmen's Hospital, were authorized by the legislative committee and hearings were also held by the Appropriations Committee at the same time or at a subsequent time, and after both committees and the Congress had approved them, then the Bureau of the Budget comes along and says "No. We do not think they need that building at this time."

Mr. MILES. I think the intent is to reconsider the timing of the project more than the latter purpose. Certainly the deferring of certain buildings for at least a year or more would not seem to us necessarily as going against the basic will of the Congress.

Mr. FOGARTY. It looks to me as though the Bureau of the Budget is trying to take over the work of the Appropriations Committees of the House and Senate; that they are the ones who are doing all of the talking and making all of the recommendations. I think it would

appear to the general public that perhaps we do not need appropriation committees in the House or Senate; that we have a Bureau of the Budget and that it knows all of the answers and knows much more about this problem and the effect of these programs than Members of Congress do.

Mr. MILES. They merely make recommendations to the Congress.

Mr. FOGARTY. I know. But at the same time you are under restrictions. When you come up here, you are here to justify the recommendations of the Bureau of the Budget—not your own figures, but the figures of the Bureau of the Budget. Is not that right?

Mr. MILES. The budget is that of the total administration.

Mr. FOGARTY. That is right. But they are the figures you use, not your own.

Mr. MILES. That is right, sir.

Mr. FOGARTY. You are frequently forced to take their figures in preference to your own judgment.

Mr. STEPHENS. We are faced with the same problem, Mr. Fogarty. When we get a ceiling, we have to allocate under the ceiling, so much to Freedmen's and the rest of them. And that, of course, 9 times out of 10, is against the better judgment of the program people. But we then have to give them a ceiling which is their segment or wedge of the total budget. And in the allocation of our ceiling, it is not always arbitrary, because we spend almost as much time in doing that as in originally allocating the money after getting it. But it never lets an agency do what they think they would like to do.

PUBLIC HEALTH SERVICE PROGRAM

Mr. FOGARTY. Mrs. Hobby, I do not want to prolong this hearing, but I am a little disappointed this morning in the budget you have presented on the Public Health Service. I believe the welfare of the people is going to be set back by it. I have always thought, and this committee has too since I have been on it, that the Public Health Service program was one of the most important functions of the Federal Government, because it affected so many people. And I think we are taking something away from the people if this reduction is allowed to stand.

I realize the necessity for cutting out unnecessary expenditures and waste and incompetence, and I will go along with you on everything that can be produced along that line; but it seems to me that in the overall drive to cut down on Federal expenses we should not take benefits away from the people which they would receive because of these expenditures. And thinking out loud right now, I think it is going to change the attitude of many of us on other big problems. I have always supported the foreign-aid program and our defense budgets, but I have heard many people on the floor of the House and Senate say, "Well, we are spending billions of dollars on foreign aid and defense. Why cannot we chop off a billion here or there and put it into public health?" And an action like this, when it affects so many people, I think might have the effect of making isolationists out of a certain group who believe in the services that this Public Health Service has given the people of our country.

I am just thinking out loud. I have not given it much thought, but that is the way I am thinking now. I think the Public Health

Service is second to none in the operations of our Federal Government, and I know they are doing more for the people of the country than any other agency of the Government. I cannot condone the whittling away at some of these institutes we have set up to make definite inroads on the killing diseases of mankind. Because of the progress that has been made over the past 8 or 10 years, I do not think we should stop it or retard it or take a chance of retarding it. That is what you people are recommending when you come up here and say that you think the States are in a position to assume a greater load. I think they are, too, but it is a question of whether they will or not. If they do not, then it is the people who are going to be hurt. There are some States that I do not think can do it.

I know you have a problem, but, as far as these institutes are concerned, I know they are vulnerable because you are not bound by law, such as you are in the case of the old-age and survivors insurance and some other programs, where the basic law provides that we have to make certain payments or match funds of the local communities. That is why I can see that this public-health budget was a little vulnerable. But I am sorry to see this happen. I think it is going to retard and hurt the program, as I see it, on an overall basis.

From what little time you have been in this job, do you not think this Federal program of public health is necessary?

Secretary HOBBY. I think they are performing a very fine service, Mr. Fogarty. It is very, very difficult to cut services once established.

Mr. FOGARTY. We have been placed in the same position, too, almost every year since I have been on this committee. We have made some cuts. We knew it was a difficult thing to do, but we knew we had the responsibility for making some cuts, and we did. I think we always showed pretty good results, but we never went this far in Public Health, and there was never any attempt on the floor of Congress to cut down these public health grant-in-aid programs in the past. I do not think there should be unless we know just what is going to happen to them. The Bureau of the Budget has not taken the time to find out what will happen if these grants are not made and how the programs will be affected.

Anything I have said has not been in criticism of you, Mrs. Hobby, because I feel you are in sympathy with these programs, and I am sure you are going to do a good job, and I want to help you do it. But I am just expressing my own thinking on this subject which has built up over the past 7 or 8 years since I have been interested in it.

Secretary HOBBY. Thank you, Mr. Fogarty.

(Discussion off the record.)

TUESDAY, APRIL 14, 1953.

OFFICE OF THE SECRETARY

WITNESSES

RUFUS E. MILES, JR., DIRECTOR OF ADMINISTRATION
LEO L. MILLER, EXECUTIVE ASSISTANT
MRS. ELLEN S. WOODWARD, DIRECTOR OF OFFICE OF INTERNATIONAL ACTIVITIES
CLARK TIBBITTS, CHAIRMAN, COMMITTEE ON AGING
M. A. STEPHENS, BUDGET OFFICER
WALTER HAMBLETON, BUDGET EXAMINER

SALARIES AND EXPENSES

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate		$950,000	$1,120,000
Reimbursements from non-Federal sources		143,000	180,000
Reimbursement from other accounts		4,650	4,329
Obligations incurred		1,097,650	1,304,329
Comparative transfer from—			
"Salaries, Office of the Administrator, Federal Security Agency"	$632,888		
"Salaries and expenses, division of service operations, Office of the Administrator, Federal Security Agency"	554,411		
"Salaries and expenses, Public Health Service"	43,114	40,300	
"Control of venereal diseases, Public Health Service"	22,000	34,825	
"Salaries and expenses, Office of Vocational Rehabilitation"	9,156	9,664	
"Salaries, expenses, and grants, National Heart Institute, Public Health Service"	20,032	32,000	
"Salaries and expenses, Bureau of Old-Age and Survivors Insurance, Social Security Administration"	17,696	28,890	
"Salaries and expenses, Bureau of Public Assistance, Social Security Administration"	3,972		
Total obligations	1,303,269	1,243,329	1,304,329

NOTE.—Reimbursements from non-Federal sources shown above are from: The Federal old-age and survivors insurance trust fund pursuant to the Labor-Federal Security Appropriation Act, 1954, and the proceeds of sale of personal property (40 U. S. C. 481 (c)).

Obligations by activities

	1952 actual	1953 estimate	1954 estimate
1. Executive direction	$94,314	$107,980	$107,980
2. Program coordination and development	132,342	140,825	165,125
3. Publications and reports	96,131	63,430	63,430
4. Administrative services	356,534	373,686	409,386
5. General services	623,948	557,408	558,408
Total obligations	1,303,269	1,243,329	1,304,329

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Total number of permanent positions	244	227	239
Full-time equivalent of all other positions	2	2	2
Average number of all employees	222	211	220
Average salaries and grades:			
General schedule grades:			
Average salary	$5,240	$5,362	$5,428
Average grade	GS-7.3	GS-7.5	GS-7.5
Crafts, protective, and custodial grades:			
Average salary	$2,765	$2,822	$2,863
Average grade	CPC-2.5	CPC-2.8	CPC-2.8
01 Personal services:			
Permanent positions	$1,079,579	$1,052,554	$1,110,554
Part-time and temporary positions	9,326	7,875	7,875
Regular pay in excess of 52-week base	4,188	3,984	3,984
Total personal services	1,093,093	1,064,413	1,122,413
02 Travel	17,123	16,620	18,620
03 Transportation of things	659	675	675
04 Communications services	19,444	16,399	16,979
05 Rents and utility services	1,250	1,000	1,000
06 Printing and reproduction	62,703	59,289	59,289
07 Other contractual services	48,270	49,523	49,523
08 Supplies and materials	19,274	9,791	10,211
09 Equipment	40,191	24,886	24,886
15 Taxes and assessments	1,262	733	733
Total obligations	1,303,269	1,243,329	1,304,329

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year			$95,000
Obligations incurred during the year		$1,097,650	1,304,329
		1,097,650	1,399,329
Deduct:			
Reimbursable obligations		147,650	184,329
Unliquidated obligations, end of year		95,000	112,000
Total expenditures		855,000	1,103,000
Expenditures are distributed as follows:			
Out of current authorizations		855,000	1,008,000
Out of prior authorizations			95,000

Mr. BUSBEY. The committee will come to order.

We will take up first this afternoon the appropriation request for fiscal year 1954 for the salaries and expenses of the immediate Office of the Secretary of the Department of Health, Education, and Welfare.

Mr. Miles, I believe you are going to testify with respect to that appropriation request?

Mr. MILES. Yes, Mr. Chairman.

Mr. BUSBEY. You may proceed.

Mr. MILES. Thank you.

GENERAL STATEMENT

Mr. Chairman and members of the committee; whenever a reorganization occurs, it is not an easy matter to make a clear comparison between what has gone before and what will come after the reorganization. The transition from the Federal Security Agency to the Department of Health, Education, and Welfare is no exception.

Although the change is not extensive in the constituent agencies of the Department, it is substantial in the Office of the Secretary.

The Secretary has already summarized the most important effects of the reorganization plan and has discussed the need for strengthening the leadership and management functions of the Office of the Secretary. The purpose of this statement is to present in a somewhat more detailed way the financial requirements of the Office of the Secretary.

There are four appropriation requests for 1954 concerning the total "Office of the Secretary:" (1) Salaries and expenses, Office of the Secretary; (2) Salaries and expenses, Office of the General Counsel; (3) Salaries and expenses, Office of Field Services; and (4) Surplus property disposal, Office of the Secretary. This statement concerns only the first of these four. A separate statement on each of the other three appropriations will be submitted following the testimony on this statement.

BREAKDOWN BY ACTIVITY

In 1954 the appropriation "Salaries and expenses, Office of the Secretary" will have 4 so-called activities instead of 5. "Executive direction" and "Program coordination and development" have been combined, since it no longer seems feasible to separate them. We have, therefore, the following 4 activities for 1954, with the following positions and dollar requirements for both personnel and miscellaneous expenses:

	Positions	Dollar requirements
1. Executive Direction and Program Coordination	45	$342,045
2. Publications and Reports	10	63,430
3. Administrative Services	79	455,291
4. General Services	117	569,563
Total	251	1,430,329

The actual appropriation request is $1,226,000, with $200,000 by transfer from the old-age and survivors insurance trust fund and $4,329 by reimbursement.

A detailed tabular comparison has been provided to the committee which shows the comparable amounts for 1953 and the original 1954 estimate. I should like to explain, briefly, the changes which we are proposing.

Two of the above activities definitely require strengthening, as the Secretary has said. These are "Executive direction and program coordination" and "Administrative services." In the other two activities there is no change, either from the 1953 appropriation or from the original 1954 budget in the number of positions requested. In respect to these latter two activities—"Publications and reports" and "General services"—the detailed explanations of the need for funds are sound as they stand, except for the need to add 50 security investigations costing $11,155 which were not in the previous budget.

ACTIVITIES TO BE STRENGTHENED

Combing now to the two activities which definitely require strengthening, previously discussed briefly by the Secretary, some of the needed

strengthening will come about directly as a result of the reorganization plan and some is being effected by executive action. Five statutory positions have been established, compared to four authorized previously. These are: The Secretary; the Under Secretary, two Assistant Secretaries; and a Special Assistant to the Secretary (Health and Medical Affairs). This, therefore, adds one statutory position. This position, plus a secretary, may be said to be the only additional position actually required by departmental status. The same impetus toward improved Government management, however, which has brought about the rapid approval of the reorganization plan also makes equally necessary other strengthening of the top staff of the Department. All of the remaining improvements in the staffing of the Office of the Secretary which I shall describe below were recommended to the Bureau of the Budget independently from and in advance of submission of the reorganization plan, based on clear essentiality.

PERSONNEL INCREASES

The net increase in positions for all 4 activities requested for the Office of the Secretary is 24, as compared with 1953. Actually, a number of other positions are being changed in content and in grade, as always occurs during a reorganization, but the net increase is 24 positions over 1953. Eleven of these positions come under the activity heading "Executive Direction and Program Coordination," and 13 of them come under the heading "Administrative Services." These 24 are, as nearly as direct comparison permits:

	Positions
Executive direction and program coordination:	
Special Assistant to the Secretary (Health and Medical Affairs) and his secretary	2
Security officer and staff	4
Defense planning officer and secretary	2
Liaison officer, private agencies, and secretary	2
Additional secretary-stenographer	1
Subtotal	11
Administrative services:	
Director of administration and secretary	2
Budget and finance	4
Planning and statistics	4
Organization and methods	2
Additional secretary-stenographer	1
Subtotal	13
Total	24

I should like to discuss each of these increases briefly and then provide you later with any additional information you may need.

SPECIAL ASSISTANT TO THE SECRETARY

In respect to the first of these—the Special Assistant to the Secretary (Health and Medical Affairs), the President's Reorganization Plan No. 1, which just became law, presents a very concise statement. It says that this official—

> * * * shall review the health and medical programs of the Department and advise the Secretary with respect to the improvement of such programs and with respect to necessary legislation in the health and medical fields * * *.

No staff is requested except for a secretary for this Special Assistant.

NEW SECURITY OFFICE

The Secretary has already discussed with you the clear justification for a new security office. (Actually that discussion was deferred and will be held later.) We are by no means sure that adequate funds are included for this purpose. That is one of the many reasons we feel it so important to have the limited amount of flexibility which would be permitted by the authority to make small transfers of funds between appropriations.

DEFENSE PLANNING OFFICER

The Defense planning officer is budgeted as a single job with a secretary. This officer will help, so far as this Department is concerned, redress the imbalance which now exists in our defense program because of lack of adequate civil and related defense on the part of Government departments and agencies. It is incumbent upon each department to see that it both plans for its own self-protection and helps in every reasonable way to promote the civil defense of the country by cooperating fully with the Federal Civil Defense Administration. I should like to enter in the record separately a fuller statement of the essential activities of the defense planning officer.

As the Secretary has pointed out, the number of private agencies in the fields of health, education, and welfare is staggering. Most of them feel, very understandably, that they should at any time be able to present their points of view to the Secretary. There are not enough hours in the day for the Secretary to listen and talk to these groups. The last 3 months have demonstrated beyond any doubt that an additional full-time person is needed to help carry this heavy burden.

DIRECTOR OF ADMINISTRATION

In future budgets, it seems to me the term "Administrative services" as an activity title ought to be changed. This activity includes most of the functions which are intended, on behalf of the Secretary and the Under Secretary, to make sure that the Department is being run efficiently and economically. As the Secretary has said, the new position of Director of Administration is intended to tie together better than has been possible in the past, the important functions of policy formation and improved management. The Director of Administration is expected not only to help the Secretary make sure that existing programs are well administered in accordance with law, but also to explore and discuss with top officials of the Department and when appropriate, with the Congress, ways of improving the effectiveness and reducing the cost of programs which may require changes in law.

PERSONNEL INCREASES FOR ADMINISTRATIVE SERVICES

The 13 additional people requested under the heading "Administrative Services" are all required for improved administrative controls which should lead to program improvements and savings throughout the Department. The Secretary has already discussed and emphasized the need for strengthening our budget and fiscal staff, our organization and procedural studies, and our administrative reporting. In respect to 4 of these positions in the Budget and

Fiscal Office, 2 in the Office of Administrative Planning, and 1 in the Office of the Executive Assistant, detailed written justifications have already been presented to you. We shall be glad to explain the urgency of these needs further, if you wish.

PLANNING AND STATISTICS OFFICE

The Planning and Statistics Office deserves special comment, since no previous written explanation has been made of the functions of this Office. This Office, consisting of 2 professional and 2 clerical people, will do 3 things: (1) It will review and develop out of the great variety of statistical data in the Department key reports upon each program needed for proper management control; (2) it will make sure that the statistical programs of the Department are better knit together than they have been heretofore; and (3) it will, when called upon, make studies to assist the Director of Administration and other top officials of the Department in developing recommendations for modifying existing statutes in the interest of efficiency and effectiveness. At the present time we are in the almost fantastic situation of not having a single trained, competent statistician in the Office of the Secretary. An office of 2 people to perform these functions in a Department of tremendous complexity and 37,000 people seems almost below a minimum level, but it is surely a step in the direction of the type of improved management stressed by the Hoover Commission and by others interested in economical and effective governmental administration.

REQUEST FOR APPROPRIATION LANGUAGE PROVIDING TRANSFER AUTHORITY

I should like to add a further word of explanation and emphasis to what the Secretary has said about the desirability of authorizing a limited degree of fiscal flexibility to the new Department by including appropriation language permitting, where necessary for efficiency and economy, transfers of small sums between appropriations. Since there is a 2-year span between the formulation of regular operating budgets in a department and the final expenditure of the appropriation, it is almost always true that unforeseen situations arise. The need for funds in one appropriation may increase slightly while the need elsewhere may not be quite so urgent. The small adjustments that are needed may pinch very acutely. It would seem eminently wise management to permit a reasonable degree of flexibility to make small shifts between appropriations to take care of such unforeseen situations.

Rather than take more of your time in an opening statement, I think it would be more profitable if I were to endeavor to answer your questions. You will realize, I am sure, that in this statement I have, for obvious reasons, concentrated upon the points of increase. I have not talked about the activities where no increases are requested. This is to conserve your time—not to imply that these may be taken for granted. They, too, are of very great importance to the successful operation of the Department.

We have a number of tabular comparisons which have been furnished you. I hope they provide you with the data you need. If not, we shall see that you are furnished whatever you wish.

Thank you, Mr. Chairman, and members of the committee for the opportunity to present this statement.

FUNCTIONS OF DEFENSE PLANNING OFFICER

Mr. BUSBEY. On page 5 of your prepared statement you stated:

I should like to enter in the record separately a fuller statement of the essentia activities of the defense planning officer.

Do you have that statement with you at this time to enter in the record?

Mr. MILES. Yes; I do, Mr. Chairman.

Mr. BUSBEY. Without objection, it will be so entered.

(The statement referred to is as follows:)

DEFENSE PLANNING OFFICER

The functions of this officer are to be as follows:

1. *Civil defense planning.*—Continuing liaison with FCDA in perfecting and testing arrangements under section 302 of Public Law 920 and Executive Order 10346 to assure maximum use of departmental facilities and services by FCDA in event of a civil defense emergency. To illustrate: One of the programs to be developed covers detection and control of communicable diseases arising from enemy attack and the protection of the civilian population from other public health hazards incident to such an attack, including training of State and local personnel.

2. *Postattack planning.*—This activity is under ODM leadership (formerly under NSRB) and deals with restoration of industrial production and minimum community facilities and living arrangements immediately following a civil defense emergency. The Department is represented on the central committee for postattack rehabilitation, and is to be specifically responsible for developing a program for welfare and maintenance of income under postattack conditions. One objective of such a plan would be to adapt OASI and regional public-assistance personnel to the handling of cash relief and compensation in the event of enemy attack.

3. *Peacetime disasters.*—Under Public Law 875 and Executive Order 10427, the Department must make plans and preparations in anticipation of its responsibilities to alleviate suffering and damage resulting from natural (peacetime) disasters. Liaison with FCDA is required and in event of Presidential declaration of a major disaster delegations of additional responsibility might be anticipated. For example: Assignment of additional staff for food and drug inspection work or funds for the rehabilitation of a water or sewer system.

4. *Mobilization readiness.*—This is a joint military-civilian project under ODM leadership. The departmental responsibility is to estimate and keep current the health, hospital, water and sewer, and educational requirements for critical materials (both for construction and current needs) in event of full mobilization. It includes also estimates of manpower resources and requirements in these fields. In event of mobilization, departmental responsibility would include allocation of critical materials for these purposes.

5. *Other liaison.*—The Department keeps in touch with the Defense Areas Advisory Committee created under Public Law 429 and ODM Order 20 and is required to survey and report on any community situation in which a shortage of community facilities is the principal problem. In this connection, the Department works closely with the Defense Department, Atomic Energy Commission, and Housing and Home Finance Agency.

6. *Intradepartmental coordination.*—This involves internal leadership with the constituents in developing such plans as are necessary to be in a state of readiness to cope with the health, welfare, and education aspects of the defense program. Studies are made of the normal operations and facilities of the Department so that, insofar as possible, disaster planning may be built into existing organizations and a transition to emergency operations (when required) may be made in an orderly, effective and rapid manner. Designated representatives or committees of constituent organizations provide staff work or specific problems and facilitate integrated departmental and regional effort. Constituent organizations develop plans for the training of field personnel who in turn will train and assist State and local governmental officials to develop their training programs to meet defense and disaster situations.

CIVIL DEFENSE EMERGENCY PLANS

Mr. MILES. May I also enter in the record Executive Order 10346, which is the most important order concerned with civil defense and which has a very important bearing on the work of the defense planning officer?

Mr. BUSBEY. Surely.

(The Executive order referred to is as follows:)

EXECUTIVE ORDER 10346. PREPARATION BY FEDERAL AGENCIES OF CIVIL DEFENSE EMERGENCY PLAN

By virtue of the authority vested in me by the Federal Civil Defense Act of 1950, approved January 12, 1951 (Public Law 920, 81st Cong.), and as President of the United States and Commander in Chief of the Armed Forces of the United States, it is hereby ordered as follows:

SECTION 1. In furtherance of national planning for the utilization of the personnel, materials, facilities, and services of the Federal departments and agencies which will be required in the event of a civil-defense emergency, each Federal department and agency shall, in consultation with the Federal Civil Defense Administration, prepare plans for providing its personnel, materials, facilities, and services pursuant to the provisions of section 302 of the said Federal Civil Defense Act during the existence of a civil-defense emergency. The plans of each department and agency shall take into consideration the essential military requirements of the Department of Defense with respect to such department or agency.

SEC. 2. In addition to the plans required by section 1 hereof, each Federal department and agency shall prepare plans for maintaining the continuity of its essential functions at the seat of Government and elsewhere during the existence of a civil-defense emergency. The personnel, materials, and facilities required for this purpose shall be exclusive of the personnel, materials, and facilities required for the execution of the plans prepared pursuant to section 1 of this order. In the preparation of the continuity plans required by this section, each department and agency shall consult with the Federal Civil Defense Administration with respect to the civil-defense aspects of its functions. In order to achieve uniformity of planning for the continuity of essential functions, the National Security Resources Board shall establish such standards and policies as it may from time to time deem desirable. That portion of the continuity plans of a department or agency which involves its functions at the seat of Government shall become effective upon approval by the President, and that portion, if any, which involves functions performed elsewhere shall become effective upon approval by the head of the department or agency concerned.

SEC. 3. The Federal Civil Defense Administrator shall assist the departments and agencies by indicating the types of personnel, materials, facilities and services considered useful for civil-defense purposes in time of emergency; arrange for the use of such personnel, materials, facilities, and services as are not required for maintaining the continuity of the essential functions of the departments and agencies; and coordinate such arrangements with national, State, and local civil-defense plans.

HARRY S. TRUMAN.

THE WHITE HOUSE, *April 17, 1952.*

NEED FOR DEFENSE PLANNING OFFICER

Mr. BUSBEY. What new developments have taken place that make it necessary to have this Defense planning officer?

Mr. MILES. Mr. Chairman, the Executive order to which I just referred, Executive Order 10346, instructed the various departments

and agencies of the Government to do everything they possibly can to help in the civil-defense program. May I just read two sections of that Executive order and then comment upon them:

SECTION 1. In furtherance of national planning for the utilization of the personnel, materials, facilities, and services of the Federal departments and agencies which will be required in the event of a civil-defense emergency, each Federal department and agency shall, in consultation with the Federal Civil Defense Administration, prepare plans for providing its personnel, materials, facilities, and services pursuant to the provisions of section 302 of the said Federal Civil Defense Act during the existence of a civil-defense emergency. The plans of each department and agency shall take into consideration the essential military requirements of the Department of Defense with respect to such department or agency.

SECTION 2. In addition to the plans required by section 1 hereof, each Federal department and agency shall prepare plans for maintaining the continuity of its essential functions at the seat of government and elsewhere during the existence of a civil-defense emergency. The personnel, materials, and facilities required for this purpose shall be exclusive of the personnel, materials, and facilities required for the execution of the plans prepared pursuant to section 1 of this order. In the preparation of the continuity plans required by this section, each department and agency shall consult with the Federal Civil Defense Administration with respect to the civil-defense aspects of its functions. In order to achieve uniformity of planning for the continuity of essential functions, the National Security Resources Board shall establish such standards and policies as it may from time to time deem desirable. That portion of the continuity plans of a department or agency which involves its functions at the seat of government shall become effective upon approval by the President, and that portion, if any, which involves functions performed elsewhere shall become effective upon approval by the head of the department or agency concerned.

Mr. Chairman, also there was completed last fall a report which was jointly sponsored by the Department of Defense, the Federal Civil Defense Administration, and the National Security Resources Board, which was commonly called the East River project. That was a total survey of our civil-defense program, and it came out with the definite recommendation that the various departments and agencies of Government which are sometimes thought of as non-defense agencies, ought to gear in with the Federal Civil Defense Administration far more effectively than they have before in carrying out the kind of program envisioned by this Executive order.

There are a great many things that the 37,000 employees in the Federal Security Agency could do to help support a civil-defense program in the United States, and we need to work more closely with the Federal Civil Defense Administration than we have in the past if we are to have as effective a civil-defense program as we need and as our facilities permit if they are properly organized.

Mr. BUSBEY. When did the President sign that Executive order?

Mr. MILES. April 17, 1952. That was after it was possible to budget for any defense-planning officer in the current fiscal year, and the Civil Defense Administration took some time in beginning to work out the arrangements. We are only now beginning to get in position where I feel that our services are very urgently needed to do a better planning job in making use of the facilities of the Department of Health, Education, and Welfare for civil-defense purposes.

Mr. BUSBEY. This Executive order was issued almost exactly a year ago.

Mr. MILES. Yes, sir.

Mr. BUSBEY. We have had two supplemental bills from the agency since then. Why did this interest start so suddenly?

Mr. MILES. Well, sir, it has been a growing thing. We have tried to handle it without asking for supplementals, as I am sure you would wish us to do, but it has been an onerous burden. We have worked overtime trying to do the work, and still have not been able to meet the needs.

INTERPRETATION OF EXECUTIVE ORDER

Mr. BUSBEY. You interpret the Executive order as meaning that you should set up this position in the Department, and all other departments should do likewise?

Mr. MILES. I would interpret it to mean that all departments should carry out suitable planning, and if it takes at least a single full-time person, as it does in our Department, I should assume that the other departments would have responsibility for doing the same thing. I would guess that some of the other departments might have even larger staffs for this sort of thing than we do; although I must say that the responsibilities we have in the field of health and welfare gear in so closely with civil defense that I cannot think of another department or agency in which civil-defense planning is more vital than in the Department of Health, Education, and Welfare.

INTERDEPARTMENTAL COORDINATION

Mr. BUSBEY. Is not the Civil Defense Administration supposed to look after that work?

Mr. MILES. To a degree, Mr. Chairman; yes. It is anticipated that if the Civil Defense Administration wishes to carry on any large-scale planning program within the Department of Health, Education, and Welfare, it will secure the funds and transfer those funds to us. This is one position only, and involves working with the Civil Defense Administration, the Office of Defense Mobilization, the Department of Defense, to some degree the State Department, and possibly with other agencies of Government. We have talked with the Civil Defense Administration and they do not regard it as their responsibility to make a transfer of funds for this kind of a top coordinating job, but they do agree that it is their responsibility to make a transfer of funds with respect to any large-scale planning program which may have to be undertaken within our Department.

Mr. BUSBEY. Well, it seems from the testimony we have been hearing that other departments of Government transfer funds very freely for their activities in your Department. I do not see why they cannot provide for a transfer of funds for this position.

Mr. MILES. Mr. Chairman, we have explored this matter very carefully with the Civil Defense Administration and with the Bureau of the Budget. In respect to this case of an overall coordinating position, which involves not only civil defense but the Office of Defense Mobilization and the Department of Defense, the Civil

Defense Administration does not feel a sufficiently clear responsibility to make a transfer of funds. That is simply the situation.

REQUEST FOR STATISTICIAN POSITION

Mr. BUSBEY. I notice you deplore the fact that you do not have a single trained, competent statistician in the Office of the Secretary.

Mr. MILES. Yes, sir.

Mr. BUSBEY. One of the new positions you are requesting is for such a statistician?

Mr. MILES. Yes, sir.

Mr. BUSBEY. What will his duties be?

Mr. MILES. Well, his duties will comprise, as I indicated briefly in the statement, three main things.

Let me put it this way: We will have two men in an Office of Reports and Statistics, which will have responsibility for seeing to it that the Secretary is provided with the basic kinds of statistical reports which she needs to keep herself fully informed all the time as to how the Department is operating, and to make sure that she has the key index figures and other figures which are needed to show just where we stand on a current and regular basis. That is one important responsibility.

A second one will be to see that the statistical operations which are scattered throughout the agency will be knit together in a better way than they have heretofore. For example, we have scattered throughout the agency responsibility for collecting various kinds of disability statistics. Those statistics are collected in the Social Security Administration, in the Public Health Service, and in the Office of Vocational Rehabilitation. We do not know, frankly, whether or not those statistics at the present time are collected in the most effective and efficient way, or whether by a review of those statistics it may be possible to actually effect economies, so that there is better coordination between the constituents.

MAINTENANCE OF FIXED PROPERTY RECORDS

Mr. BUSBEY. What do you do at the present time so far as keeping records concerning fixed property of the various agencies in the Department?

Mr. MILES. I would like to have Mr. Miller answer that, please.

Mr. MILLER. You mean by "fixed property" the property outside of buildings and items of that kind?

Mr. BUSBEY. Yes. It is my understanding that St. Elizabeths Hospital and Freedmen's Hospital are the only two agencies at the present time which have any record of fixed property throughout the Department.

Mr. MILLER. Well, insofar as St. Elizabeths Hospital is concerned we have just completed a joint survey there with the General Services Administration and the General Accounting Office and have brought that process into order. The recommendations are being installed as time goes along.

Freedmen's Hospital has a system. We have not surveyed it by this joint group.

There is a record throughout the agency of a kind in each of the establishments. Some of them do not meet the standards they should; to that we readily agree. But with what resources we have in connection with GSA and GAO we are trying to make property accounting one of our major management improvement projects in the Department.

Mr. BUSBEY. Am I correct in my thinking when I say that the Public Health Service keeps no detailed record of its equipment?

Mr. MILLER. No, I do not believe you are entirely correct. Now, you may be partially correct. I have not had time to study the survey report on the part of the Public Health Service that is being surveyed at this time, and that is the National Institutes of Health. They have found some areas there which need improvement.

Insofar as property is concerned at their central distribution warehouse in Perry Point, Md., there is a fine record there and each item of supply and equipment is well identified and well recorded. The hospitals have reasonably good property accounting. We think it needs some improvement.

AUDITORS

Mr. BUSBEY. Will this statistician you are requesting in the Office of the Secretary have anything to do with freeing the grant-in-aid auditors from the jurisdiction of the program people?

Mr. MILES. I would say, Mr. Chairman, that the statisticians will not have anything to do with that. I can say that there is a study under way at the present time which is designed to help the Secretary determine whether or not it is desirable to give the auditors a greater degree of independence from the program people than exists at the present time.

Mr. BUSBEY. I personally think it is very important that the auditors be given a large degree of independence, and not be kept tied in so closely with the program people whose activities they are auditing.

Mr. MILES. I am sure you realize, Mr. Chairman, that the auditors are administratively not under the program people at the present time, but they are limited to a degree by program decisions which are made not within the immediate Office of the Secretary but which are made by the program people in the various constituents of the Department. It is that subject which is being carefully studied at the present time.

Mr. BUSBEY. You think that as a result of this reorganization some of those matters will be given very careful consideration?

Mr. MILES. Yes, sir.

Mr. BUSBEY. I hope that we have some very favorable reports a year from now.

BUDGET REQUEST

You are asking now for $1,430,329 for 251 positions for 1954.

Mr. MILES. Yes, sir.

Mr. BUSBEY. Which compares with $1,243,329 and 227 positions for 1953; is that right?

Mr. MILES. Yes, sir.

Mr. BUSBEY. At this point we will insert in the record the additional detailed breakdowns which have been submitted to the committee, to show the changes from 1953 and also the changes from the Truman budget.

Incidentally, I note that footnote 2 is missing on the first page. I believe those figures are made up mostly by the OASI transfers, but it would be well to add that footnote.

Mr. HAMBLETON. Footnote 2 is on page 1D attached. It is a long footnote. That is the reason it was put on a separate sheet.

Mr. BUSBEY. I stand corrected.

(The information follows:)

Salaries and Expenses, Office of the Secretary

Page No.	Item	1953 appropriation (estimate) [1]		Original 1954 estimate [1]		Revised 1954 estimate		Revision compared with—			
								1953 appropriation (estimate)		Original 1954 estimate	
		Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
	Total appropriation or estimate		$950,000		$1,120,000		$1,226,000		+$276,000		+$106,000
	Additional amounts available for obligation [2]		293,329		184,329		204,329		−89,000		+20,000
	Total obligations		1,243,329		1,304,329		1,430,329		+187,000		+126,000
	APPLICATION OF FUNDS										
	ACTIVITIES										
4	1. Executive direction (and program coordination)	14	$107,980	14	$107,980	45	$342,045	+31	$234,065	+31	$234,065
5	2. Program coordination and development	20	140,825	25	165,125			−20	−140,825	−25	−165,125
21	3. Publications and reports	10	63,430	10	63,430	10	63,430				
23	4. Administrative services	66	373,686	73	409,386	79	455,291	+13	81,605	+6	45,905
37	5. General services	117	557,408	117	558,408	117	569,563		12,155		11,155
	Total obligations	227	1,243,329	239	1,304,329	251	1,430,329	+24	187,000	+12	126,000

[1] Funds shown in 1953 and original 1954 estimate are the submissions to the Congress for the Federal Security Agency prior to creation of Department of Health, Education, and Welfare.

Footnote 2 appears on page 1225.
See explanation of change from original 1954 estimate on page 1224.
NOTE.—Summary of revised 1954 increases over 1953 and original 1954 estimate appear on page 1226 attached.

Salaries and Expenses, Office of the Secretary

Explanation of increase over original 1954 estimates

Activity 1. The increase of 31 positions and $234,065 are distributed as follows:

	Number of positions	Amount of increase			
		Salaries	W. A. E.	Travel	Total
Transferred from activity II, "Program coordination and development":					
Federal-State Coordinator and secretary	2	$94,982	$2,500	$6,000	$103,482
Office of International Relations	4				
Committee on Aging and Geriatics	7				
Assistant to Administrator, and stenographer	2				
	15				
New positions for immediate office of secretary (including 1 secretary for Federal-State Coordinator included in original 1954 estimate)	16	130,960	----------	3,730	134,690
New positions for Security Office (including 2 secretarial)	4	24,545	----------	1,000	25,545
W. A. E. employees; pay in excess of 52-week base and other salary adjustments	----------	882	3,500	----------	4,382
Total	35	251,369	6,000	10,730	268,099
Less 4 positions available in 1953 which are abolished in 1954	−4	−34,034	----------	----------	−34,034
Net increase	+31	217,335	6,000	10,730	234,065

Activity 2. The decrease of 25 positions and $165,125 is explained below:

	Number	Salaries	W. a. e.	Travel	Total
Presently available (1953) positions:					
(a) Transferred to activity "Executive direction and program coordination"	[1] 15	$94,982	$2,500	$6,000	$103,482
(b) Abolished	5	36,043	----------	1,300	37,343
Additional positions requested in original 1954 estimate:					
(a) Transferred to activity "Executive direction and program coordination" (1 stenographer for Federal-State Coordinator)	1	3,175	----------	----------	3,175
(b) 4 newly requested program positions deleted	4	20,125	----------	1,000	21,125
Total	−25	154,325	2,500	8,300	165,125

[1] See breakdown under activity 1.

Activity 4. Increase over original 1954 estimate is 6 positions and $45,905, as follows:

	Number of positions	Amount
Director of Administration and secretary	2	$20,360
Planning and Statistics staff (including $1,000 travel)	4	25,545
Total	6	45,905

Activity 5. No new positions requested; $11,155 is required to pay for 50 security investigators at approximately $225 each.

Footnote 2

Additional amounts available for obligation

		1953	Original 1954	Revised 1954	
Advance from Old Age and Survivors Insurance trust fund.		$143,000	$180,000	$200,000	For services performed for Bureau of Old Age and Survivors Insurance.
Reimbursements		4,650	4,329	4,329	Initial mail sort for Food and Drug Administration and Office of Education; service of laborers furnished constituents.
Comparative transfers from:					
Salaries and expenses, Public Health Service.	$40,300				Transfer of mail and messenger personnel of Public Health Service to centralized operation in Office of Secretary.
Control of venereal diseases, Public Health Service.	34,825				Transfer of 7 Public Health library personnel to central library and 2 personnel methods positions to central personnel office in Office of Secretary.
Salaries and expenses, Office of Vocational Rehabilitation.	9,664				$4,664 is for transfer of 1 Vocational Rehabilitation library position to central library and $5,000 to transfer obligations for "Aging" program to Office of Secretary.
Salaries, expenses, and grants, National Heart Institute, Public Health Service.	32,000				To transfer financing of "Aging" program to Office of Secretary.
Salaries and expenses, Bureau of Old Age and Survivors Insurance.	28,890	145,679			To transfer financing of "Aging" program ($20,000) to Office of Secretary and $8,890 for transfer of 2 personnel methods positions to central personnel office in Office of Secretary.
Total		293,329	184,329	204,329	

The comparative transfers shown in 1953 totaling $145,679 are distributed as follows:

$116,789 from PHS and OVR	+$950,000 annual appropriation for 1953	=Comparable 1953 appropriation of $1,066,789
$28,890 from OASI	+$143,000 annual transfer from OASI for 1953	=Comparable 1953 OASI transfer of $171,890
$145,679		

The amounts available for obligation in 1953 are summarized below:

	1953	Revised, 1954	Increase (+) or decrease (−)
Comparable appropriation or estimate	$1,066,789	$1,226,000	+$159,211
Comparable advance from OASI	171,890	200,000	+28,110
Reimbursements from other accounts	4,650	4,329	−321
Total obligations	1,243,329	1,430,329	+187,000

SALARIES AND EXPENSES

OFFICE OF THE SECRETARY

	Summary of revised 1954 increase over—			
	1953		1954 original estimate	
	Positions	Amount	Positions	Amount
New positions for immediate Office of Secretary	16	$134,690	15	$131,515
Increased salaries for Secretary and Under Secretary		+7,500		+7,500
Less positions abolished:				
(a) Executive direction	−4	−41,534	−4	−41,534
(b) Program coordination and development	−5	−37,343	−9	−58,468
Net increase for immediate Office of Secretary	7	63,313	2	39,013
New positions for Security Office	4	25,545	4	25,545
Consultant services, $3,500, and pay in excess of 52-week base, etc., $882		4,382		4,382
Net increase, executive direction and program coordination	11	93,240	6	68,940
Office of Administration	3	24,020	2	20,360
Organization and methods	2	9,715		
Budget and finance	4	22,325		
Planning and statistics staff	4	25,545	4	25,545
Net increase, Administrative Services	13	81,605	6	45,905
Security investigations		11,155		11,155
Miscellaneous expenses (other than travel which is included in above figures)		1,000		
Net increase, General Services		12,155		11,155
Total increase	24	187,000	12	126,000

IMMEDIATE OFFICE OF THE SECRETARY

Additional positions over those available in 1953

	Grade	Amount
16 new positions:		
Assistant Secretary		$15,000
Do		15,000
Special assistant to Secretary for Health and Medical Affairs		15,000
Assistant to the Secretary	GS-16	12,000
Do	GS-16	12,000
Defense planning and liaison officer	GS-14	10,600
Liaison officer to private agencies	GS-14	9,600
Assistant to Secretary for Federally Aided Corporations	GS-14	9,600
Secretary	GS-8	4,620
Do	GS-8	4,620
Do	GS-8	4,620
Do	GS-8	4,620
Do	GS-6	3,920
Do	GS-5	3,410
Do	GS-4	3,175
Do	GS-4	3,175
		130,960
Plus travel		3,730
		134,690
Plus increased salary rates for Secretary, Under Secretary		7,500
Less positions abolished:		
Executive direction (4 positions):		
Assistant Federal Security Administrator	GS-17	13,000
Assistant to the Administrator	GS-15	10,800
Do	GS-14	10,000
Liaison officer	GS-13	7,734
		−41,534
Program coordination and development (5 positions available in 1953):		
Assistant Administrator for Program	GS-18	14,800
Program consultant	GS-14	9,800
Secretary	GS-9	5,435
Clerk-stenographer	GS-5	3,785
Do	GS-4	3,175
		36,995
Plus travel $1,300 less lapse $952		348
		−37,343
Net increase, Immediate Office of the Secretary		63,313

Additional positions over those available in 1953

	Grade	Number	Amount
Security Office (4 new positions):			
Security Officer	GS-14	1	$9,600
Investigator, technician	GS-13	1	8,360
Secretary (stenographer)	GS-5	1	3,410
Clerk-stenographer	GS-4	1	3,175
		4	24,545
Plus travel			1,000
		4	25,545
The increase in positions in Administrative Services is distributed as follows:			
Office of Administration (3 new positions):			
Director of Administration	GS-18	1	14,800
Secretary	GS-9	1	5,560
Secretary-stenographer	GS-5	1	3,660
		3	24,020
Administrative methods (2 new positions):			
Organization and methods examiner	GS-12	1	[1] 6,340
Clerk-stenographer	GS-4	1	3,175
Total, personal services		2	9,515
Plus travel funds for new examiner			200
		2	9,715
Budget and finance (4 new positions):			
Budget examiner	GS-12	1	7,040
Accountant	GS-12	1	7,040
Do	GS-11	1	5,940
Accounting clerk	GS-4	1	3,175
		4	23,195
Less lapse			1,670
Total, personal services		4	21,525
Plus travel for new personnel			800
			22,325
Planning and statistics (4 new positions):			
Chief	GS-14	1	9,600
Statistical analyst	GS-13	1	8,360
Secretary	GS-5	1	3,410
Clerk-stenographer	GS-4	1	3,175
		4	24,545
Plus travel			1,000
			25,545
Total (13 new positions and travel funds)			81,605

[1] $7,040 less $700 lapse.

INCREASE UNDER REVISED BUDGET

Mr. BUSBEY. You know, we Members of Congress receive a lot of mail about economizing from our constituents. Of course, the popular game is for everybody to economize except where it affects them personally. I notice that this is the only appropriation request which involves an increase over the Truman budget; in total you have made a substantial cut. I wonder how we can justify this request when we go out on the floor of the House if we are going to be cutting down all the other parts of the Department substantially? What am I going to tell them to substantiate this increase, in other words?

Mr. MILES. Well, Mr. Chairman, I think the answer to that is simply this: That the responsibility for managing a department of the size and complexity of this new Department of Health, Education, and Welfare is so great that if you want the Secretary to carry out

these responsibilities without killing herself she just has to have additional help.

I wish we had the actual overtime records of the tremendous amount of time which has been put in by the staff of the Office of the Administrator, now Office of the Secretary, in these past 3 months. I have never seen such a tremendous load upon the Office of the Administrator. All of us who have been connected with the Office have had a heavier load of work than we have ever had in the past. It is almost literally a back-breaking matter

I feel sorry for a lot of the people, including the Secretary, who have just driven themselves to tremendously long hours. I feel that if this kind of a situation has to continue indefinitely the Secretary would really be in a desperate situation. I really do.

I wish the investigators from the committee had come around and seen the work going on at 7:30 and 8 in the evening around the Secretary's Office.

Mr. BUSBEY. Well, I must admit that I have had occasion to call the Secretary rather early in the morning on several occasions, and rather late at night, and I have been able to find her in her office, so I know what you say with regard to her is true, and I presume that she has to have some help to be able to work.

Mr. MILES. Yes, sir. Among other things, just the mail and telephone calls which have come in since the 20th of January are so much greater than occurred before that you just would be amazed at the contrast in terms of workload. In addition to that, if the kind of management which is to be expected from the Secretary is to be achieved this is absolutely necessary. As you say, Mr. Chairman, you hope that a year from now when we come back we will have some good reports to make. If that sort of thing is looked forward to, then I think we have to have the staff to be able to produce on your expectations.

Mr. BUSBEY. I am sure that you can appreciate the predicament this committee would be in if we should recommend to the House of Representatives approval of this increase in positions, and they in turn should approve it, and then if some substantial progress in the way of administration and coordination during the next year is not demonstrated when you appear for your 1955 appropriation requests.

Mr. MILES. I appreciate it fully, Mr. Chairman.

Mr. BUSBEY. I do not want to be put in a position of having to apologize for an increase a year from now.

I do think that the Secretary is entitled to be given a chance, at least, to show what she can do in that position. Probably the Congress will feel that she should have the tools, which in this case is additional positions, with which to prove her ability to bring about these reforms and to show a marked improvement in the operation of the Department.

If you want to add anything for the record in justification of these positions feel free to do so, because we want you to have every opportunity to justify them. After all, this amounts to approximately a 20 percent increase in this office, according to my calculations.

(The following was subsequently submitted:)

Mr. Chairman, there follows an extension of remarks which you suggested that I might prepare and insert.

The Federal Security Agency, as originally established in 1939, consisted of a group of semiautonomous units. Gradually this has changed and except for a

number of functions vested directly in the Office of Education and the Public Health Service most functions are now vested in the Secretary, subject to such delegation as may be decided upon by the Secretary.

These developments, plus consolidation of such functions as the grant-in-aid audit and the formation of a regional-office structure for all agencies of the Department, have made it necessary to assume greater responsibility for the review of policy decisions made by program administrators. Other changes taking place since 1946 have expanded the scope of responsibility for review of operations.

Congress has approved a number of major program additions, such as the establishment of new Institutes at the National Institutes of Health for Mental Health, Heart, Dental, Arthritis and Metabolic Diseases and, finally, for Neurological Diseases and Blindness. Also in Public Health are the hospital survey and construction program and the Water Pollution Control Act.

New legislation provided for the survey and the construction of school facilities in federally affected areas and for furnishing assistance to local educational agencies for maintenance of schools in federally affected areas. These are extensive and far-reaching programs.

With the repeal of Federal taxes on oleomargarine, the Food and Drug Administration was made responsible for regulating the manufacture, packaging, distribution, and sale of this product, including regulating the serving of oleomargarine in public eating places. Another important amendment was added to further regulate the dispensing of habit-forming and other dangerous drugs.

Responsibility for Federal Credit Union activities was transferred to the Federal Security Agency and the Administrator was directed to establish a bureau to administer these functions.

In 1950 and again in 1952 the old-age and survivors insurance functions were substantially expanded.

All of these increased the flow of questions to the Administrator's office for determination as to policy. The Nation's increasing interest in international affairs has imposed steadily mounting duties on the Secretary in the exchange of students, point 4 activities, and other programs of health and welfare. The very nature of the Department's functions identify it with planning to care for people in civil-defense matters.

Title X of the Classification Act of 1949 Management Improvement Plan and Awards, problems of internal security, complete responsibility for position classification, the development of activity schedules and the maintenance of related controls as required by the Bureau of the Budget and the General Accounting Office, joint accounting regulations under the Budget and Accounting Procedures Act of 1950—all require an increasing amount of staff time from the Secretary's office.

No additional staff was provided for any of these purposes. In fact, in the face of these increasing activities, resources were gradually cut. The most drastic decrease was in the 1952 estimates which, though reduced below the 1951 level, was still further reduced in the amount of $219,000. Consequently, our resources are now at a point below that which would enable us to deal effectively with our many problems.

This is illustrated in a recent letter from the General Accounting Office to the Bureau of the Budget in connection with our 1954 estimates. This letter states that our request for budget and accounting activities—

"* * * was wholly inadequate. * * * The Agency is in no position to carry out responsibilities assigned to it by action of Congress in 1950. * * * It is urged that the Bureau of the Budget add to the Administrator's appropriation the sum of $75,000 for the fiscal year 1954, specifically earmarked to the Administrator for the exclusive use within his Office for a budget and accounting improvement program."

What the General Accounting Office said regarding budget and finance activities is illustrative of all activities in the Office of the Secretary. Existing staffs have absorbed all that can be expected of them.

When the Agency was organized, if something went wrong, criticism was directed primarily at the program administrator. Today, responsibility rests on the Secretary and the President. Congress frowns on the old theory of very loosely organized and poorly supervised activities. The Hoover Commission report points up failures in administration and specifically recommends that heads of departments and agencies be provided with adequate staff assistance, if they are to achieve efficiency and economy in program operations. Your com-

mittee and other committees of the Congress rightfully look to the heads of departments for results. To get these results requires adequate staffing at the point where the responsibility is assigned, namely, the Office of the Secretary.

Mr. BUSBEY. Mr. Fogarty?

CONGRESSIONAL ATTITUDE TOWARD PREVIOUS APPROPRIATION REQUESTS

Mr. FOGARTY. Mr. Chairman, following up what you have just said' I think that Mr. Miles could have made another point in answer, but I presume that he is in an embarrassing position on the other side of the table.

As you know, in the past 4 or 5 years whenever this request for salaries and expenses for the Office of the Administrator came before this committee the committee arbitrarily made severe cuts mainly because of the personality of the former Administrator. As a result, this particular office suffered greater cuts than any other part in the old Federal Security Agency.

On top of that, the Office suffered additional cuts on the floor for the same reason, because of some of the philosophies expressed by the former Administrator. I can see where the Office was cut down below what they should have had in past years because of that, and they have to get back to some sort of a standard.

I also can see where it would be difficult for anybody on the other side of the table to make that sort of a statement, but that has been the case for the past 4 or 5 years.

QUALIFICATIONS REQUIRED OF SPECIAL ASSISTANT TO THE SECRETARY

Now, Mr. Miles, with respect to the special assistant to the Secretary for Health and Medical Affairs, does this person have to have any certain background to qualify for that position?

Mr. MILES. The reorganization plan, Mr. Fogarty, said that the special assistant to the Secretary, who shall be appointed by the President by and with the advice and consent of the Senate shall be from among persons who are recognized leaders in the medical field with wide nongovernmental experience. Subsequently an inquiry was made as to whether or not this official had to be an M. D. and a statement was made that the present administration intended to appoint an M. D. to this position, so he will be a doctor of medicine with wide nongovernmental experience in the medical field.

Mr. FOGARTY. I suppose that could mean they could select some doctor whose only experience had been in clinical medicine, where he has had a job which did not give him the broad background of experience with all the diversified affairs you have under this agency.

Mr. MILES. Yes, sir.

Mr. FOGARTY. Which contains the Public Health Service, the Children's Bureau, Vocational Rehabilitation, and others whose activities are directly or indirectly related to health and medical activities, and whose activities—especially in Public Health—include a great deal of research.

Mr. MILES. That would theoretically be possible, Mr. Fogarty.

Mr. FOGARTY. I hope it will not be so.

Mr. MILES. I am not sure that there is anybody in the country from outside the field of Public Health itself who has the widest knowledge of all these programs.

Mr. FOGARTY. But some certainly would have more knowledge than others.

Mr. MILES. That is right.

Mr. FOGARTY. You could have a doctor who just practiced medicine all of his life in his office and had nothing to do with these programs at all. Others may have had some experience in the research field.

Mr. MILES. I am sure it is the intent to have a person with a broad point of view and background.

Mr. FOGARTY. That is all, Mr. Chairman.

DIVISION OF AGING AND GERIATRICS

Mr. BUSBEY. Before we go on to our next item, I should like to ask Mr. Tibbitts briefly about this Division of Aging and Geriatrics, described briefly on page 13 of the justifications. Will you give us a little background on that, as to just what you are doing and where you expect to take us in that activity?

GROWTH IN OLDER POPULATION

Mr. TIBBITTS. The background, Mr. Chairman, comes out of recommendations of people not only in the Department but throughout the United States. We have a very rapidly growing population of older people who are without demonstrated usefulness in the community. Because of that circumstance these people are becoming discouraged, bewildered, concerned over what their position is in the community, what it is with reference to their families, how they are going to have financial security, health security, and worthwhile lives.

ESTABLISHMENT OF STATE COMMISSIONS ON AGING

There are 15 States now which have recognized this to the extent of setting up official commissions or committees appointed either by the governor or set up as a result of legislative action. At least five more States have such legislation before them at the present time.

PROGRAM OF COMMITTEE ON AGING AND GERIATRICS

What we are trying to do, I think, is composed essentially of three things. There are many people in different parts of our Department and in other Federal departments who are working with various phases of the aging problem. It is our experience and our belief that through extending their knowledge to the broad areas of aging their present work may be made more effective. So one thing we are trying to do is to increase the competency of our own people and to encourage or assist other departments to do the same thing.

In our committee we have representation from the Department of Labor, from Housing, and from Agriculture.

Second, we are facilitating if not encouraging the States and communities throughout the country to study the problems of aging and to set up facilities and services which will enable more older people to remain self-sufficient, to feel that they are a part of the community.

We feel that it is essentially a State and community problem, because that is where the people live.

Mr. BUSBEY. When did you start this study?

Mr. TIBBITTS. I think it was back in about 1948 that the first committee was set up within the agency. I was not there at the time.

The work of that committee led to the preparation of a report which was sent around the country to about 400 people who were known to be interested in aging. A number of those people wrote back and said that we were on the right track. They felt it was desirable to have a national meeting on aging that would bring together the people around the country who are interested, so that they could pool their ideas and see where we ought to be going.

Accordingly, there was a national conference on aging held in the summer of 1950. About 800 non-Federal people from State governments, local governments, private agencies, physicians, businessmen, labor leaders, and so on, attended and took part in that meeting.

Our present Committee on Aging and Geriatrics was set up a few months after that, when it became obvious that there was a continuing need for informational service to the community.

DIVISIONAL POSITIONS

Mr. BUSBEY. How many positions do you have in the Division of Aging and Geriatrics?

Mr. TIBBITTS. I think it is about seven. There are two professional and the rest are clerical.

POSSIBILITY OF PROGRAM EXPANSION

Mr. BUSBEY. Do you have any fear that this might be the start of another large subdivision or agency of the Department of Health, Education, and Welfare?

Mr. TIBBITTS. No, sir, I do not; because I think that the existing units of the Department will carry the primary burden of responsibility. I would hope that eventually there would be another professional person or two in a central unit, because the interest in this situation is growing so fast that it is now impossible to keep up with it.

Mr. BUSBEY. Well, I will not take a back seat to anyone with respect to my interest over a long period of time in the problems of the aged of our country, but I have seen so many of these little subdivisions start in Government, with just a small number of people, and each year they add a little and add a little and add a little, and eventually they have blossomed into tremendously large organizations.

Mr. TIBBITTS. Mr. Chairman, I cannot see our becoming an operating agency in the ordinary sense of the word. The Public Health Service is there. The Social Security Administration is there. There is the Office of Vocational Rehabilitation and Education.

Mr. BUSBEY. I am very happy to get that reassurance from you.

Are there any further questions, Mr. Fogarty?

IMPORTANCE OF FEDERAL PROGRAM ON AGING

Mr. FOGARTY. I do not know how correct you are in that assurance to the chairman, but if the population of this country continues to live longer, as it has in the past 20 years, unless the local communities

and States do something, people are going to look to the Federal Government to do something about the many problems that will result.

I do not know what can be done. Any time I have ever asked any questions about it, no one knows the answer. There is no real program of any kind for them. The States do not know what to do about it. The States are appealing to you.

I know that my State passed a resolution a couple of years ago in the house and senate to set up a commission, but when they got it set up there was no one in Rhode Island who knew anything about the problem. We did not even know how many old people there were. We had to find out how many people over the age of 65 were living in the State. It surprised everybody to find out the number of people who were over 65 who were living in our State at that time. I know that with the rise in the cost of living in the past 8 or 10 years they just cannot get by on the social security benefits and most of them do not want the benefits. They want jobs if they can get them.

I think that helping these people is a big problem, and it is a problem that someone has to face up to sometime, because apparently they cannot help themselves. They are looking for jobs and too many positions are closed to them just because they are old.

I do not know how much of a problem this will be, but I think the next few years will probably tell us.

I hate to see a person, just because he is 67 or 68 years old, if he is in good physical shape, turned down for a job, especially in a State or Federal Government. But this happens in our own State government and happens in the Federal Government under civil service. I just read of a person in my own State who was endorsed for one of the Federal jobs in the State, and because he was 67 years old they say he is too old for the job. To me that is a hard thing to tell anybody, if he is in good physical shape and he is only 67 years old. He can perform the job. It is hard to say that he is too old. I wonder what that fellow is thinking about all this.

INCREASE IN AGING POPULATION

Mr. TIBBITTS. I agree with you, Mr. Fogarty. We do not even yet begin to see the immensity of this thing. We have a net increase of 1,000 older people each day.

Mr. FOGARTY. Each day?

Mr. TIBBITTS. Each day. That is a net increase. That is the number coming into the age period, less the number who are dying. That is about 400,000 a year.

Mr. FOGARTY. I often wonder what some Members of Congress would say if the people decided that because they were 60 years old they were not physically capable of representing their people and should not run for office. I can just see the uproar of Congress then.

Some of these poor unfortunate people, who are barely existing today because they cannot get a job, because of some regulation of industry or business or civil service, are being deprived of their livelihoods when they are physically able to work. I think it is a big problem. I do not know what the answer is.

I do not know what you can tell them. You cannot tell them anything that is of any help, can you?

Mr. TIBBITTS. Well, we are trying to find out what the possibilities are. The age at which employment discrimination begins comes about 20 years earlier in many occupations than the age you mentioned. It is in the forties for men, as well as in the thirties in some cases for women.

ADVISABILITY OF ELIMINATING COMPULSORY RETIREMENT BASED ON AGE

One of the lines of attack which is being followed now is to try to get rid of compulsory retirement based on an arbitrary age. I think there are more and more establishments which are beginning to keep selected people on. There are some places where we can definitely use middle-aged or older people. There are serious shortages of school teachers, nurses, practical nurses, office workers, social workers, and sales workers; and there are not enough young women to make it possible to fill those positions. Some employers and personnel-management people are beginning to see the possibility of bringing middle-aged women back into those jobs. Where they have done it and have observed it carefully, they are beginning to see that perhaps those people may be even better, because they have a maturity and they are willing to get the refresher training and they make valuable employees.

We know now that a person of that age has a much longer worklife expectancy on a particular job than does a young person just coming out of school. But that is on employment. That certainly is not going to take care of the needs of the 13 million retired mothers that we have at the present time and the 5 million or 6 million formerly gainfully employed workers who are retired, which is a total of nearly 18 million or 20 million people now who need some kind of activity.

OPPORTUNITIES OF HANDCRAFT EMPLOYMENT

There is a movement—I do not know how far it will go—to find out what opportunities handcraft offers. It is believed that many older people are interested in learning how to do things through which they express themselves. They enjoy it. But it is also realized they are not going to do it very much unless they get some kind of recognition and perhaps money income from it.

As you said at the beginning, we really do not know what the answers are. Every State which has a commission is doing what the Rhode Island one is doing. Illinois is doing it and California is doing it. They are trying to find out what the problems are.

Mr. FOGARTY. I know when the commission was set up in Rhode Island its officials had no one to go to, and I know that they asked you for your advice on how to get started. People are looking for some leadership like that in the country at the present time.

Mr. TIBBITTS. Within the next 2 weeks I am going to be in four more States. I just wish I knew more of the answers. That is why I said to the chairman I hoped that eventually there would be another professional person or two in the unit.

Mr. FOGARTY. I can at least satisfy myself that if the Federal Government would take the lead in a field like this we would be preventing more costly demands on the Federal Government in the next 4 or 5 years, because this thing is going to come to a boiling point

someday, and then when the demands are made on Congress it might cost us 10 times as much as it is costing us at the present time.

IMPORTANCE OF MEDICAL RESEARCH PROGRAMS

I feel just exactly the same way in regard to these cuts in the programs of the Public Health Service. The more I think of them the more I am convinced that if this curtailment program is carried on for 2 or 3 years the resentment will be so great in the country, and the demand will be so great by the people of the country for the Federal Government to do something in this field, and to do much more than we are doing, that it will cost us much more than if we continue at the present level. I know that 5 or 6 or 7 or 8 years ago the demand was there, and the Congress did something about it, but this committee kept it in line. There were bills introduced in the Congress to appropriate $100 million for research in cancer—that much in one bill alone. I can see where bills like that will be reintroduced if the Bureau of the Budget continues in its attitude of cutting down grants like those of public health, which affects all the people.

That is all, Mr. Chairman.

Mr. BUSBEY. Thank you very much.

TUESDAY, APRIL 14, 1953.

OFFICE OF FIELD SERVICES

WITNESSES

CHESTER B. LUND, DIRECTOR
RUFUS E. MILES, JR., DIRECTOR OF ADMINISTRATION
M. A. STEPHENS, BUDGET OFFICER

SALARIES AND EXPENSES

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate		$1,835,000	$1,930,000
Reimbursements from non-Federal sources		375,000	413,000
Obligations incurred		2,210,000	2,343,000
Comparative transfer from—			
"Salaries, Office of the Administrator, Federal Security Agency"	$2,023,666		
"Salaries and expenses, Division of Service Operations, Office of the Administrator, Federal Security Agency"	305,769		
Total obligations	2,329,435	2,210,000	2,343,000

NOTE.—Reimbursements from non-Federal sources shown above are pursuant to the Labor-Federal Security Appropriation Act, 1954.

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
1. Field services	$1,461,422	$1,363,545	$1,401,545
2. State grant-in-aid audits	717,781	706,708	801,708
3. State merit system services	150,232	139,747	139,747
Total obligations	2,329,435	2,210,000	2,343,000

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Total number of permanent positions	462	437	470
Average number of all employees	436	416	442
Average salaries and grades:			
General schedule grades:			
Average salary	$4,614	$4,724	$4,738
Average grade	GS–6.1	GS–6.1	GS–6.2
01 Personal services:			
Permanent positions	$2,012,645	$1,963,664	$2,083,364
Regular pay in excess of 52-week base	7,771	7,582	7,582
Payment above basic rates	3,000	3,054	3,054
Total personal services	2,023,416	1,974,300	2,094,000
02 Travel	104,824	113,258	126,558
03 Transportation of things	4,327	3,180	3,180
04 Communications services	106,484	63,000	63,000
05 Rents and utility services	8,654	2,845	2,845
06 Printing and reproduction	12,948	11,070	11,070
07 Other contractual services	7,628	6,000	6,000
08 Supplies and materials	38,964	26,962	26,962
09 Equipment	21,940	9,235	9,235
15 Taxes and assessments	250	150	150
Total obligations	2,329,435	2,210,000	2,343,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year			$140,000
Obligations incurred during the year		$2,210,000	2,343,000
		2,210,000	2,483,000
Deduct:			
Reimbursable obligations		375,000	413,000
Unliquidated obligations, end of year		140,000	155,000
Total expenditures		1,695,000	1,915,000
Expenditures are distributed as follows:			
Out of current authorizations		1,695,000	1,775,000
Out of prior authorizations			140,000

Mr. BUSBEY. We have before us now for consideration the appropriation request for fiscal year 1954 for the Office of Field Services, Department of Health, Education, and Welfare.

Mr. Lund, we will be very happy to hear from you at this time.

Mr. LUND. Thank you.

GENERAL STATEMENT

Mr. Chairman and members of the committee, if it is the pleasure of the committee, I would like to make a background statement relative to the operation of the Office of Field Services of the Department of Health, Education, and Welfare. The Office was established by congressional directive in fiscal 1949, with responsibility for the general organization, integration, and evaluation of all field activities, and in particular to assist the then head of the agency in the administration of its regional offices. More recently—1952—the Office was given the added responsibilities of operating of the Division of Grant-in-Aid Audits, the Division of State Merit Systems, and the Division of Surplus Property Utilization—all of which functions are performed primarily through the regional offices.

The departmental office operates with a staff of 17 for the Division of Field Services. It functions to insure uniform application of Department policy in the field and to promote organizational and operating efficiency among the twenty-odd field programs. It has major responsibility, for example, for the general supervision and direction of the personnel, supply, mail, files, payroll, and related fiscal, space, communications, and other business-management services for all of the divisions under its operation. It develops, issues, and reviews all instructions to the field pertaining to operations and management, to insure proper coordination. It visits regional offices to assist regional directors in the operation of their offices. It prepares a weekly regional and field letter containing official instructions to field establishments throughout the country. It conducts special studies on management activities and maintains staffing controls for the regions and for the divisions under its supervision at the departmental level.

CONSOLIDATION OF REGIONAL OFFICES AND STAFF

The Department's regional offices were also established in 1949, by congressional directive. At that time separate regional organizations were maintained by the Social Security Administration, the Public Health Service, and the Office of Vocational Rehabilitation, comprising a total of more than 30 distinct offices, each with its own management and service organization, and without operating connection with one another. The House committee report on the 1949 supplemental appropriation bill contained the statement that—

> there is absolutely no justifiable basis for each major bureau or segment of the Federal Security Agency with field activities, maintaining separate regional offices and staffs independent of each other. A single set of regional offices functioning for the entire Federal Security Agency is certainly feasible, logical, and more economical than having numerous regional offices under the several independent bureaus.

It is my best judgment that the objectives of the Congress in directing this consolidation have been carried out in very large measure. Under the present system the thirty-odd former offices are combined in 10 Department regional offices, each housed in 1 building, uniform regional boundaries, and with all programs provided with management services from a single central source. Each office is under the direction of a regional director who represents the Department in the region, and who is responsible for integration of all program activities and the carrying out of Department policy. The constituent units of the Department are represented on the staff of the regional office by regional representatives who have technical program responsibility.

The integrated regional offices have been able to operate at an annual level of expenditure approximately half a million dollars below the level for the separate operations as conducted prior to 1949. Efficiency of the centralized management services has been further demonstrated by their ability in recent years to absorb a one-third increase in workload without additional operating staff. Since the consolidation there have been added to the regional operation by congressional enactment the programs for water pollution control, surplus property utilization, and school assistance in federally affected areas. The old-age and survivors insurance law has been

twice amended, calling for substantial increases in field staff to be serviced.

Today the regional offices are servicing 11,333 employees with a staff of only 292 service employees, as compared with some 8,000 serviced with a staff of 296 when the offices were originally established. Output per employee in such measurable management functions as payrolling, voucher audit, and the like is substantially above the standard levels for such operations set by the Bureau of the Budget. A recent survey of our total field operations indicates that we have been able to keep approximately current with our increased workload responsibilities by overtime work in all areas except that of records management activities. There, we are currently 4 man-years behind disposal scheduled.

Major gains have also been achieved in the objectives of integration and more uniform operation of the Department's varied program responsibilities. Under supervision of the regional director, related programs have been brought into much closer operating relation. Necessary contacts with the States in the grant-in-aid programs have been regularized and simplified. Through increasing decentralization of responsibility to the regions both the management operations and services to the States have been speeded and given increased effectiveness. Greater uniformity in both formulation and application of policy has been accomplished. Much remains to be done along these lines, but the results which have been attained, in my belief, are widely recognized as indicating the success of this rather unique governmental experiment initiated by the Congress, of integrating in a single regional system the operations of a multiprogram agency such as the Department of Health, Education, and Welfare.

DIVISION OF GRANT-IN-AID AUDITS

The principal function of the Division of Grant-in-Aid Audits is to audit annually grants-in-aid made to State agencies for the 25 grant-in-aid programs administered by the Department of Health, Education, and Welfare through the Public Health Service, the Social Security Administration, the Office of Vocational Rehabilitation, and the Office of Education. The audit is made to determine whether these grants were expended in accordance with applicable Federal and State laws for the purpose for which the funds were appropriated by the Congress.

Approximately 93.3 percent of all funds appropriated to the Department are expended in grants-in-aid to States. Audits will be made this year on State expenditures of $2,400,000,000, more than one-half of which is from Federal funds.

Audits are made on a test-check basis. The Division makes approximately 2,280 audits in a fiscal year. Where good internal control exists the auditors examine a sample of transactions. If the auditor's examination discloses errors or improper expenditures, he extends the percentage of his sample to 100 percent of the transaction.

Where disbursements are made by counties and other local subdivisions, the audit must be made at the local level. There are approximately 1,200 local units to which the auditors must travel to perform the audit function each year.

The main problem of the Audit Division in performing its function is the serious shortage of field auditors. To audit the 1953 expenditures requires 90 man-years of field audit staff time. Currently only 72 man-years are available. The Division is 18 auditors short of enough staff to handle the current annual workload. With the previous backlog of 20 man-years as of July 1, 1952, this means a backlog of 38 man-years by July 1, 1953. To solve this problem we are requesting an additional 20 field audit positions. Even with this requested increase, considering the 1954 workload, we would be 47 man-years behind on July 1, 1954, if expenditures continue at present levels.

Audits for school and hospital construction projects must be made promptly so that contractors and vendors can be paid. These audits, therefore, are given first priority with the result that audits of the regular programs are delayed even more disproportionately than a staff shortage would indicate.

Prior to the reorganization of the Federal Security Agency in 1948, from 133 to 205 auditors were employed to perform audits for the Social Security Administration alone. From 1948 to June 1952 the audit staff was progressively reduced down to 108 persons to perform the total workload after reorganization for the Social Security Administration, the Public Health Service, the Office of Education, and the Office of Vocational Rehabilitation. In addition there has been added by congressional action other new or expanded programs such as amendments to the Social Security Act, the hospital construction program, and the school construction program. It is estimated that in 1954 that it will be necessary to audit 500 hospital construction projects and about 700 school construction units.

The progressively increasing workload continuing at the same time that the number of auditors available has been progressively reduced, presents a serious problem and we solicit your consideration.

A failure to perform the audits on time places a strain upon State and Federal relationships. These delays also mean that program bureaus and offices lack current information as to the problems of expenditures made from the grants and therefore cannot assure the Secretary, and the Secrerary the Congress, that the funds are expended for the purposes for which they were appropriated.

DIVISION OF STATE MERIT SYSTEMS

The Division of State Merit Systems was established to carry out the responsibility under the Social Security Act and the Public Health Service Act, and the regulations adopted thereunder, to find that merit systems of personnel administration are provided for and are in operation in State health and welfare agencies receiving Federal grants-in-aid. The main function of the Division is to make the necessary reviews of State personnel administration in the grant-aided State agencies and of the States governing provisions.

These reviews are made against uniform standards. These standards require substantial conformity with their provisions, the most important of which relate to (1) impartial administration of the merit system, prohibition of discrimination, and prohibition of political activity; (2) plans of position classification and compensation; (3) employment in order of merit as determined by open competitive

examinations; (4) promotion on merit; and (5) protection from removal without cause.

The reviews of merit system operations in State agency personnel administration are made by the Division's 10 regional representatives. Reports are prepared annually, covering each fiscal year, to the extent possible by the 10 regional representatives available to review more than 250 State agencies and 65 State merit systems. The State agencies and merit systems participate in the reviews and cooperate in supplying factual data for the reports. The findings of the reviews and recommendations for corrections and improvements are submitted to the State agencies and merit systems.

There is a continuous flow of new and revised provisions arising from State legislation, State agency reorganization, revision of position classification and pay plans, and numerous changes in State rules and regulations governing personnel administration which require prompt action.

In response to State requests the Division serves as clearinghouse for the exchange of information on personnel practices among the States; renders technical training assistance to the States; assists in drafting of laws and regulations; and to a limited extent provides test material for positions common to the several States. In each of the last 2 years, the Division has fully or partially filled requests by the States for over 600 examinations. The holding of examinations helps screen out incompetent applicants and leads to the appointment of the best qualified.

Even though there has been no reduction in workload, we have continued operation with a two-thirds reduction in staff since 1948. Departmental positions have been reduced by more than half since 1951. It may be that in our efforts to effect economies that we have gone too far. Currently we have sufficient funds to provide for only 5 secretaries for the 10 regional representatives. Reductions in staff have affected the quantity and undoubtedly the quality of our production.

Currently, the Division's ability to provide written test materials in response to State requests is not meeting the States' needs. The Division is attempting to build up test materials by stimulating and pooling some production of test questions by State personnel as a cooperative Federal-State project. We are not at this time able to evaluate the results of this experimental project. A survey made in January 1953 indicates that no State merit system favors discontinuance of the examination service. The State merit systems estimate that it would cost them an aggregate of $200,000 a year to develop for themselves the examination material which they are now furnished by the Division at an approximate cost of $25,000 per year.

This program has contributed in a large measure to the stability of State merit systems. It has, I believe, forestalled proposals to blanket into the career service, personnel who have not qualified by examinations.

The accomplishments of the merit system program can be reflected in part by the statement of the Council of State Governments in its report on Federal-State relation to the Hoover Commission, wherein they state:

National insistence upon Statewide merit system for particular programs has undoubtedly improved the administration of those programs.

The report further states that many civil-service agencies have been "strengthened and revitalized" by the service rendered to them.

The Division also performs these same functions for the Bureau of Employment Security of the Department of Labor on a reimbursable basis for services and travel. This arrangement was effected to achieve economy and coordination and to avoid duplication of contact with State agencies.

AUDIT WORKLOAD BY PROGRAM, FISCAL YEAR 1953

Mr. BUSBEY. Thank you, Mr. Lund.

Would you submit for the record a breakdown of the man-years devoted to auditing activities for fiscal year 1953 by program, such as school construction, vocational rehabilitation, public assistance, and so forth?

Mr. LUND. Yes, sir.

(The information requested is as follows:)

Summary of estimated audit workload (man-years), fiscal year 1953

Program: [1]	*Work performed and to be performed, 1953*
Public assistance and child welfare services	33.3
Health (PHS–CB)	10.4
Vocational rehabilitation	5.0
Vocational education	3.1
Joint merit systems	.5
Hospital construction	8.8
School construction	6.3
Miscellaneous grants and projects	.3
Miscellaneous activities of auditors	4.2
Total	71.9

[1] There are 25 programs but, due to integrated program activities of the separate State agencies, the records of audit time are maintained by these major groupings.

BUDGET INCREASES

Mr. BUSBEY. Your request is for $2,343,000 and 470 positions, which is an increase of $133,000 and 33 positions over 1953.

Mr. LUND. That is correct.

Mr. BUSBEY. The increase is for 20 additional audit positions and, according to page 50 of the justifications, 13 new GS–4 positions in the regional offices which are necessary because, and I quote the justifications, "the severe budget cuts in fiscal year 1953 necessitated the reduction of 13 positions under 1952." So this is just a request to restore a cut made by the 82d Congress; is that right?

Mr. LUND. That is correct. You will notice that all of the positions are on the selective basis and that they are not the same. We tried to make a complete analysis of the workload in each office and are recommending increases in those areas where we have a backlog and only in those areas.

DEPARTMENTAL ACTIVITIES NOT PRESENTLY REGIONALIZED

Mr. BUSBEY. You were speaking about how these various divisions were regionalized. Just what activities of the Department are not regionalized at the present time?

Mr. LUND. Currently, the Office of Education does not have a full conplement of staff in all of its divisions. The food and drug programs work closely with us, but because of the difference in boundary lines of their offices they have not come into the full regional pattern. We had hoped that we might have accomplished this by now, but there have been some problems in connection with it. We hope we will be able to accomplish it during this coming year.

SEPARATE ADMINISTRATIVE OFFICES OF MARINE HOSPITALS

Mr. BUSBEY. Can you explain to the committee why the marine hospitals have separate administrative offices, even when located in the same city as Department of Health, Education, and Welfare regional offices?

Mr. LUND. That problem has been discussed, and it was felt that the administration of the hospitals was a very specialized type of administration and that it would be better to leave the administration fully in the hands of the Public Health Service. The regional directors do render some service. They visit the hospitals; they give whatever assistance they can in general administration. On public relations problems, they enter into the picture, or if there are matters of special administration they may be given directives in certain areas. But the primary reason for their exclusion from the regional pattern was that it is a very highly specialized type of operation and that the Public Health Service was in a better position than we and that no money could be saved by doing the overall administration.

We tabulated, for example, such things as turnover in a hospital, where you have a great number of low-grade employees, such as charwomen and others, and we felt that it was much better to leave the administration at the point where they could more quickly fill those positions.

We could handle it at those points where the regional offices are in the same city, but in many instances the hospitals are not in the same location. The matter has not been discussed for the past 18 months.

Mr. STEPHENS. Also, it would have been a hybrid setup, because there are so many like Savannah, Memphis, New Orleans, and Seattle where we are quite a way from the regional office. I mean hospitals like that.

AUDIT WORKLOAD FACTORS FOR 1954

Mr. BUSBEY. I notice that on page 3 of your statement you say:

> Considering the 1954 workload, we would be 47 man-years behind on July 1, 1954, if expenditures continue at the present levels.

Now, if for some reason the Congress should decide not to authorize expenditures at present levels, you would not be so many man-years behind; would you?

Mr. LUND. No; we would not. We would have the problem, though, in 1954 in that all of the other hospital and construction units will come up in 1954. So it will not make a big difference in 1954. The reason we did not ask for more auditors is because we felt if the workload leveled off or there was a decrease, we could in the ensuing year pick up 47 man-years or even possibly effect a reduction. That was the line of our thinking.

AUDITING OF HOSPITAL CONSTRUCTION PROJECTS

Mr. BUSBEY. I notice that in the next paragraph you state:

> Audits for school and hospital construction projects must be made promptly so that contractors and vendors can be paid. These audits, therefore, are given first priority with the result that audits of the regular programs are delayed even more disproportionately than a staff shortage would indicate.

Why is it, then, that we have hospital construction projects that are not audited even within a year and a half or 2 years after they have been completed? That testimony was given to this committee when Dr. Cronin appeared before us.

Mr. LUND. The only reason I can see for that is this, that when a State unit sets up their hospital construction committee—and that operates by different names—we do not go in and make that audit until that committee has advised the Public Health Service they are ready for the audit and the Public Health Service in turn advises us. We would prefer, because it would give us a better distribution of the workload, if there could be a specific time schedule after the completion to make the audit. But, you see, we do not control that. We are a service agency and go in within 10 days after we receive the request.

Now, there are some hospitals—there is one in your home State of Illinois—that come in the category of a year plus, and we have never been requested to make the audit as yet.

DELAY IN STATE AUDIT REQUESTS

Mr. BUSBEY. What is the reason these State or local groups delay in asking for an audit for such long periods of time?

Mr. LUND. At the beginning of the program it was a matter of receiving equipment and supplies that were in shortage. Currently, insofar as I am able to understand the situation, I see no reason for it. I think when a hospital is constructed and is ready to operate, we should go in and do the audit. I believe the Public Health Service is studying the situation to try to remedy the long delay.

Mr. BUSBEY. They do not get their final payment until the audit is made; do they?

Mr. LUND. No; they do not.

Mr. BUSBEY. And it follows, it seems to me, that they would wish the audit made as soon as possible after the hospital is completed in order to get their money.

Mr. LUND. That is right.

Mr. BUSBEY. But the facts do not bear it out.

Mr. LUND. That is correct.

Mr. BUSBEY. I have been trying to ascertain what they have to gain by delaying this audit or the request for the audit.

Mr. LUND. I do not know that they would have anything to gain if all the materials outlined in the project have been received and are installed and are on site. As I say, the only logic I can see is at the point and period when some of this specialized equipment was difficult to get.

Mr. BUSBEY. I brought up the question previously with Mr. Miles concerning the possibility of getting these auditors out from under the—I believe I would go so far as to say—domination of the program people. What do you have to recommend along that line?

Mr. LUND. Well, one has several factors to consider. For example, in the Public Health Service Act there is a provision that the Surgeon General may waive certain classes of audits. The law specifically puts it under his jurisdiction. There are instances where we have differences of opinion, and where we do take the exception, and the Office of the Surgeon General makes the evaluation and final determination. If he chooses to waive it, within certain limits, he has that prerogative under the law.

The only way I see that this could be changed would be that we either take firmer position in the administrative office that these items come to the top for final action or a change in the law itself.

We do not have that same situation prevailing with any of the other programs. When we are sure the audit is factually accurate we do send it back to the States for added information. In some cases they do present us with additional evidence that they are in line with the regulations. In these cases we cut out that portion of the audit.

I think the records will show that since the Audit Division has been moved to the Administrator's Office, now the Secretary's Office, that the percentage of audits sustained has increased.

Does that answer your question?

Mr. BUSBEY. Yes. I do not wish to embarrass you or the Public Health Service or any other agency in any way, but it appears to me that if this Auditing Division were more independent, the same as the General Accounting Office is independent of the various departments of the Government, it would be a much more practical arrangement than the present one, in which the auditors are more or less under the domination of the program people.

Mr. LUND. I might say this: I agree in principle with you that it is not good business administration for the program unit to have responsibility for the audit itself or to have too much voice in its final determination. A part of the practice, as I related, has grown up because of the fact that some of the laws themselves have given that authority specifically to the program heads. I think the tendency within the Agency has been, and is now, to hold to a strict policy, and I think we have moved forward in the last year in that direction. The matter has not been discussed with the Secretary, nor have we discussed it with Mr. Miles, but my assumption is that this matter will correct itself except in 1 or 2 areas where there is basic legislation. No one can deny the principle.

Mr. BUSBEY. I think that someone from the Agency, then, if it is as good as you seem to think it is, should recommend a change in the basic legislation.

In some respects, this reminds me of the time I was on the subcommittee that heard the testimony concerning the creation of the Central Intelligence Agency. I was not successful in my attempt, but I cannot help but be so vain as still to think I was right. I think one of the fundamental faults of the Central Intelligence Agency

today is the fact that its officials evaluate information that their men in the field gather. And in my many years experience in intelligence, we were always taught that the gathering agency should never evaluate its information. Likewise, I do not think this audit should be so closely tied in and under the domination of the program agency. I think it should be separate.

COMPLETED AND PLANNED STAFF SURVEYS

Mr. MILES. Mr. Chairman, earlier this afternoon, when you asked me about that, I was a little bit momentarily confused, and it was the merit system program which we were making and have just completed a staff study on, which has been submitted to the Secretary, concerning the balance of responsibility between the Office of the Secretary on the one hand and the constituent agencies on the other.

I do know the Secretary is also interested in making a similar determination in respect to the audit function, in order to arrive at a new conclusion and a firm conclusion as to whether or not there is some action which we ought to take in that field. And I am sure Mr. Lund and others of us in the Department will be reviewing that issue in the future and arriving at the kind of determination I know you want us to go into.

Mr. BUSBEY. It is as I said earlier in the day. I think that the Department should take the initiative and bring about these reforms itself and not wait for congressional mandates.

Mr. MILES. I agree.

REGIONALIZATION OF FIELD OPERATIONS

Mr. BUSBEY. A moment ago we were speaking about what agencies of the Department are not completely regionalized. I would appreciate it, Mr. Lund, if you would supply for the record a statement of the extent of regionalization of the work of each of the agencies of the Department.

Mr. LUND. Yes, sir.

(The information requested is as follows:)

REGIONALIZATION OF FIELD OPERATIONS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

As requested by the committee, the following is a summary of the extent of regionalization of the activities of constituent organizations and programs of this department.

1. All field operations of the Social Security Administration are conducted through the Department's regional organization, under the general administrative supervision of the regional directors. Included are the programs of the Bureau of Public Assistance—old-age assistance, aid to the blind, aid to dependent children, and aid to the permanently and totally disabled; the maternal and child-health and child-welfare programs of the Children's Bureau; all operations of the Bureau of Federal Credit Unions; the program of the Bureau of Old-Age and Survivors Insurance, operated through its 500 field offices; and the regional referees of the Appeals Council which hears appeals concerning claims in the old-age and survivors insurance system. The Bureau of Old-Age and Survivors Insurance also operated area offices in six principal cities, but these are not engaged in field operations. They constitute units of the Bureau's overall record keeping and claims review and payment operations, and are administered by a separate division from that which administers the Bureau's regional and field activities.

2. The Office of Vocational Rehabilitation conducts all of its field operations through the Department's regional system.

3. The Office of Education's programs of school construction and assistance in federally affected areas and its veterans' education functions are regionalized through the Department's system. Activities in such matters as vocational education, which are carried on by small technical staffs, operate directly out of Washington. The Office of Education operates no field establishments apart from the Department's regional system.

4. In the Public Health Service all Federal-State grant-in-aid programs and other activities such as the water-pollution-control program are regionalized through the Department's offices. The Public Health hospitals and the foreign quarantine stations, which operate as independent, technical units are not administered through the regional offices, but are subject to inspection and to certain overall supervision by the regional directors. Operation of the communicable-disease programs is directed through the Communicable Disease Center in Atlanta and the Environmental Health Center in Cincinnati. The work of the centers is carried out largely through teams sent out into the regions as needed. Staff working in the regions are under general supervision of the regional offices, and where practicable personnel, payrolling, and other services are performed for them by the regional offices.

5. The Food and Drug Administration is the only constituent of the Department which operates a separate system of field establishments, consisting of 16 district offices. Activities of the Food and Drug Administration are of a highly technical and specialized nature, and their offices in most cases include long-established laboratory organizations and equipment, many of them already housed in Federal buildings. Location of the district offices is based upon the concentration of the food and drug industries throughout the country. It has not been considered practicable or economical to move the expensive technical installations of these offices into the regional offices, even where these are in the same city; but plans have been in process of development for supplying the district offices with personnel, payrolling, procurement, and other management services from the central service units of the Department regional offices.

6. Operations of the surplus-property utilization program, and of the Department's centralized grant-in-aid audit, legal, and merit-system-service functions are all carried out in the field through its regional offices.

EXTENT OF OVERTIME WORK

Mr. FOGARTY. There is one thing that came to my mind as Mr. Lund was testifying about overtime work. I remember that a year ago his testimony was about the same.

Mr. LUND. That is correct.

Mr. FOGARTY. From all we read in the newspapers or listen to from the radio commentators, everyone in the country would think there is nobody in the Government doing a full day's work. But here today we have found 3 agencies of the Federal Security Agency that have been working overtime and 2 that are being forced to take payless furloughs. I think this Division was hit in the last 3 or 4 years the same as all others in the Secretary's office, because of personalities. I think that was the consensus of this committee when we made those cuts.

Mr. LUND. That is right. And what we are asking for is only the difference as an increase between what we were cut last year to restore it to where we were.

ESTIMATED ANNUAL SAVINGS FROM INTERNAL AUDITING

And I would like to make one other observation, if I may. That is, it is remarkable, that the prognostication of this committee at the time this organization was directed came so close to the monetary savings that have resulted. They estimated a half-million-dollar saving a year, and that is what it has been.

SURPLUS PROPERTY DISPOSAL

WITNESSES

CHESTER B. LUND, DIRECTOR, OFFICE OF FIELD SERVICES
M. A. STEPHENS, BUDGET OFFICER

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate	$130,000	$165,000	$255,000
Reimbursements from other accounts	531		
Total available for obligation	130,531	165,000	255,000
Unobligated balance, estimated savings	−2,039		
Obligations incurred	128,492	165,000	255,000
Comparative transfer to "Salaries and expenses, Office of the General Counsel, Office of the Administrator, Federal Security Agency"		−4,280	
Total obligations	128,492	160,720	255,000

Obligations by activities

Surplus property disposal—	
1952	$128,492
1953	160,720
1954	255,000

Obligations by objects

Object classification		1952 actual	1953 estimate	1954 estimate
	Total number of permanent positions	21	29	46
	Average number of all employees	15	25	42
	Average salaries and grades:			
	General schedule grades:			
	Average salary	$6,143	$5,758	$5,430
	Average grade	GS–8.6	GS–8.2	GS–8.0
01	Personal services:			
	Permanent positions	$93,491	$141,698	$227,453
	Regular pay in excess of 52-week base	360	547	547
	Payments to other agencies	14,505		
	Total personal services	108,356	142,245	228,000
02	Travel	5,948	11,600	16,425
03	Transportation of things	24	400	400
04	Communication services	2,006	4,900	5,200
06	Printing and reproduction		1,000	1,500
07	Other contractual services	44		
	Payments to other agencies	8,992		
08	Supplies and materials	1,121	475	625
09	Equipment	1,951		2,700
15	Taxes and assessments	50	100	150
	Total obligations	128,492	160,720	255,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year	$37,667	$39,858	$24,858
Obligations incurred during the year	128,492	165,000	255,000
	166,159	204,858	279,858
Deduct:			
Reimbursable obligations	531		
Unliquidated obligations, end of year	39,858	24,858	30,858
Total expenditures	125,770	180,000	249,000
Expenditures are distributed as follows:			
Out of current authorizations	94,537	145,000	229,000
Out of prior authorizations	31,233	35,000	20,000

Mr. BUSBEY. We next have for consideration the appropriation request for the Surplus Property Disposal Division of the Department of Health, Education, and Welfare.

I believe you also have a statement on that, Mr. Lund.

GENERAL STATEMENT

Mr. LUND. Yes, sir.

PURPOSE

The Federal Property and Administrative Services Act of 1949 (Public Law 152), as amended by Public Law 754 (81st Cong., 2d sess.), assigned to the Federal Security Administrator (now Secretary of Health, Education, and Welfare) three major responsibilities in the field of surplus property: (1) determination of surplus personal property needed for educational and public-health purposes, including research and allocation of that property to State agencies for distribution to educational and public-health institutions; (2) disposal of surplus real property for educational and public-health purposes, subject to the approval of the Administrator of the General Services Administration; and (3) protecting interests and rights reserved to the United States under the terms and conditions of transfers made for educational and public-health services under Public Law 152 and under a number of prior laws (Surplus Property Act and amendments) including recapture of property for use during national emergencies.

WORKLOAD

During the first 6 months of the fiscal year 1952, property amounting to $17,459,000 acquisition cost was allocated to State agencies. During the same 6-month period for 1953, $28,145,000 of personal property was allocated. It is anticipated by the General Services Administration that there will be $200,200,000 of surplus property for disposal in 1954, of which approximately $75,000,000 will be available for donation to health and education institutions. This is an increase of approximately 50 percent over the estimates of 1953. During the fiscal year ending June 30, 1952, $9,826,515 acquisition cost of land and buildings were transferred; 61 properties were transferred from one institution to another, and 28 new transfers are now pending. This is an increase of 35 percent over real-property transfers

during the previous year. The number of compliance cases requiring investigation and action by this Division has reached a backlog that will require a minimum of 2 years to complete. Many new cases have come to our attention as a result of the investigation made by the General Accounting Office of 21 State agencies. Practically all of these cases involved property transferred under other laws and by other agencies in years previous to the assignment by Congress of the responsibility to this division under Public Law 152. Fifteen cases have been referred to the Department of Justice for legal action. We are currently in the process of investigating many other cases which also may need to be referred to the Department of Justice. Our basic problem here is that in relation to the workload for allocation of both personal and real property our staff is inadequate. A summary of our anticipated workload for 1954 follows:

Anticipated donations for health and education	$75, 000, 000
Anticipated real-property transfers	12, 000, 000
Anticipated number of compliance cases	3, 000
Anticipated recapture of real-property installations	30, 000, 000
Anticipated recovery of personal property	4, 000, 000
Anticipated cash collections fiscal 1953	1, 750, 000

I especially wish to invite the attention of the committee to the cash collections effected thus far this year to the benefit of the account of the Government in compliance and transfer actions which total $1,750,000. In my statement to the committee last year, in justifying the allocations of funds, I stated that we would expect during 1953 to effect collections five times the amount of our budget. This has been accomplished.

RECAPTURE OF PROPERTY IN THE INTEREST OF THE GOVERNMENT

During the past fiscal year, $58,516,000 (acquisition cost) of real-property installations were recaptured for Government use because of the national emergency. Also during the past fiscal year this Department, in cooperation with the Munitions Board, has recaptured machine tools, electronic and other equipment needed for defense contracts having an acquisition cost of $4,625,000. This item alone has saved the Government $2½ million, or 10 times the cost of our last year's operation.

ABROGATION OF RESTRICTIONS ON REAL PROPERTY

Real-property installations which were transferred by the War Assets Administration and other units of the Government were transferred on the basis that the property be used only for educational or health purposes for a period of 20 years and were not to be sold, leased, or otherwise disposed of without the concurrence of this Department. For various reasons, many of the institutions now find it necessary to abrogate these restrictions by payment to the United States of established fair value of the property at the time of transfer. An example case of this type of transaction is where a former industrial plant, transferred to the school at a fair value of $213,794, has to be demolished because it lies in the route of a new highway. It therefore becomes necessary for the school to sell the building to the State highway department and pay the fair value of this property

to the Treasurer of the United States. Twenty cases of a similar nature are currently pending. These cases require painstaking analysis of the Government's interest and cost considerable of both travel and staff time. In some instances institutions find that they cannot put the total property acquired to proper health or educational use. This Department then attempts to reevaluate the utilization, draft new contracts with the institutions, and sell the balance of the tracts to the highest bidder for the account of the Government. This procedure entails extensive negotiations, reappraisals, review of bids, drafting of deeds, or leases, prior to final conclusion of the case. We believe these procedures are of importance. It makes possible an evaluation of educational or health utilization and places back onto tax rolls properties not essential for health and education. It is the belief of this Department that an adequate budget should be provided in order that all properties of significance may be recaptured in relation to their utilization and its potential receipts back to the Government.

AIRPLANES

One thousand one hundred and thirty-five airplanes of various types were disposed of by the War Assets Administration for educational purposes. Several hundred cases now require action by this Department to protect the interest of the Government. Because of the increased value of air equipment and planes, commercial concerns are finding ready market for these old aircraft in foreign countries, where they are being used for cargo purposes. Our findings are that many of these planes have been sold illegally by institutions to second-hand dealers who have realized tremendous profits by resale. This past year we have developed a procedure whereby institutions are permitted to sell the planes only on advertised bids whereby the net proceeds (except for advertising and incidental costs) are paid to the Government. Here again our compliance problem in investigating these cases is exceedingly great. Where illegal disposals have already been effected, thorough investigations must be made prior to taking action. In the two most recent cases that we have settled, we have recovered $10,500 to the account of the Government.

SUMMARY

In general, it is believed that this program serves educational and health institutions effectively by creating a secondary utilization for Government surpluses that would otherwise be disposed of at small gains. The program makes possible the clearing out of Government warehouses, thereby reducing rental costs. In addition, the program as currently operated is returning to the Government in cash receipts many times more than its administrative costs. Not only does this program profit the Government but it expands in needed areas educational and health facilities. Many vocational schools have been almost fully equipped and others have been able to expand their programs of education which they would otherwise not have been able to do.

Because of the heavy backlog of compliance responsibility that has been transferred to this Agency under Public Law 152, we are unable with our present staff to carry out the functions that have been

assigned. In appearing before the committee last year, I stated that I was concerned that the Agency would come in for criticism and that the Federal Government itself would come in for criticism because we did not have an adequate staff to handle the work volume. The same situation continues to exist. I would also like to invite the attention of the committee the fact that some of the criticism leveled against the Government's disposal programs result from a number of the early laws which made it possible for schools and health institutions to make outright purchases on a discount basis or receive property without restriction. The public, therefore, frequently feels that when schools or health institutions have acquired properties and have sold them at a profit, the institutions have taken advantage of the intent and purpose of the program. It is our contention that in the vast majority of cases we have investigated that the institutions have utilized the property in accordance with the laws under which they were acquired. Obviously, in a program that has made donations to more than 100,000 institutions throughout the country, there will be some trouble spots. This Department has during the last year issued new and more restrictive requirements in order to avoid most of the problems of the past. While we actually need more money in order to do this job effectively, we are requesting only a small increase in order to stay within the budget ceiling. The requested $255,000 will permit expansion of the staff in seven of our regional offices to a skeleton staff in the other regional offices. We solicit your consideration of our problems in the conduct of the responsibilities we have been assigned.

MAJOR ITEMS DISPOSED OF AS SURPLUS PROPERTY

Mr. BUSBEY. On page 1 of your statement, Mr. Lund, you state:

> During the first 6 months of the fiscal year 1952 property amounting to $17,459,000 acquisition cost was allocated to State agencies. During the same 6-month period for 1953, $28,145,000 of personal property was allocated.

What are some of the items that account for the bulk of this amount of money?

Mr. LUND. I would say that the bulk of this is furniture of all types; old cafeteria equipment; machine tools, both hand- and motor-driven; almost any type of thing that a person can conceive of that is used by the Federal Government.

ESTIMATED SURPLUS OF OFFICE EQUIPMENT

Mr. BUSBEY. Do you have any knowledge at the present time as to what surplus the Government might have in the way of office equipment?

Mr. LUND. I can only quote accurately from one location, and that is our regional office here, where I recently visited. We have, roughly, or did have before distribution, nine large vanloads full of furniture. I cannot give you the count, but I would guess we would load, roughly, 16 desks on each van. There is a great deal of filing equipment of all classes available, some poor and unusable except to the extent it can be broken down into steel sheets for other uses.

DISPOSAL OF PROPERTY OF ABOLISHED AND CURTAILED AGENCIES

Mr. BUSBEY. What is the process of disposing of the surplus property of agencies like the Wage Stabilization Board and the National Production Authority, which are being abolished or whose operations are being curtailed?

Mr. LUND. A list is prepared and is transmitted to the General Services Administration to determine the need of other Federal agencies; the other Federal agencies have an opportunity to buy it at a reduced price. If there is no need, it is declared to us for distribution to health or educational institutions.

Mr. STEPHENS. In that connection, we got some office equipment recently from the Wage Stabilization Board, and under Public Law 152 you appropriated money to us to buy equipment, and we pay them for that equipment and the money goes back in the miscellaneous receipts, so our appropriation is not enhanced or subsidized to the extent of any free equipment.

INCREASE IN AMOUNT OF SURPLUS PROPERTY FOR DISPOSAL IN 1954

Mr. BUSBEY. Further down in that same paragraph you mention the fact that there will likely be an increase in 1954 of approximately 50 percent over the 1953 estimates. Why?

Mr. LUND. That I cannot answer except to make a guess. One reason is that probably last year during the period of time there were so many investigations going on, some of the agencies were so heavily encumbered in time that they did not get to this type of item, and therefore it accumulated. My opinion is that a regular flow of property will again seek its own level.

Another reason may be the replacement of certain types of equipment by the Armed Forces; and as new material comes in and they have to clear out warehouses.

Another reason is that there have been certain expansions in Army camps where new equipment was needed, and because the Army camps were built some years ago, and only on a temporary basis, they have stripped out some of the old equipment and replaced it with new. That is just my opinion.

COMPLIANCE BACKLOG

Mr. BUSBEY. At the bottom of the first page you state:

> The number of compliance cases requiring investigation and action by this division have reached a backlog that will require a minimum of 2 years to complete.

On the basis of your past experience, about how much in collections for the Government could be expected to result from completing these cases?

Mr. LUND. I tried to take a sample the other evening and run that down. I would say that based on our current request for staff, you could expect a return next year of about $500,000. If that staff is expanded proportionately just a few more people in relation to what we have requested, I estimate a return of about $800,000 to$1,000,000.

One of the problems is funds. I have always wanted to ask for more money and for 2 years have attempted to do so then drop down

to be on a workload business basis. I felt we needed $550,000 a year for 2 years to clean this up. We would return about three times that amount a year for those 2 years. That is my best estimate.

Mr. BUSBEY. I notice in your summary of workload for 1954 that you list an estimate of 3,000 anticipated compliance cases. How does that compare with fiscal year 1953?

Mr. LUND. That is considerably in excess, it is more than 100 percent in excess, of tabulated cases. The General Accounting Office when they made their survey of the 21 States, brought to our attention a good many cases. I cannot say at this point that those cases are cases over which this agency has jurisdiction. In a sample of about 12 of those, we found that only 2 of those cases came under the present law; we have not had time to make a complete analysis. We do have cases that we feel need attention and which will return some monetary benefit to the Government in the total of 3,000.

INVESTIGATIONS OF ABROGATION OF RESTRICTIONS ON REAL PROPERTY

Mr. BUSBEY. On page 3, you mention some of your work regarding abrogation of restrictions on real property. What are you not doing that you should be doing in this field?

Mr. LUND. (1) We have all these airplanes out that are causing a lot of trouble. We have only been able to run down a few compliance cases. We are absolutely sure of 300 bad cases.

(2) I would like to reevaluate every grant of land made by previous programs—and some of our own—to every institution in this country, to see if its total utilization is in accord with its contract; pick up the parcels that are not in accord, and sell them off to the benefit of the Government.

(3) The other compliance cases we have arise out of sales. There are cases arising constantly, and we cannot be sure until we investigate that we have responsibility, because under some of the earlier laws the States had authority to sell if they wanted to, the only limitation being that the proceeds be used for educational advantages. You have a very complicated problem. The truth is, we do not know how big it is.

ESTIMATED COST OF ADEQUATE COMPLIANCE PROGRAM

Mr. BUSBEY. How much do you think it would cost to do what you really think should be done in the Department.

Mr. LUND. I think it would take $550,000 a year for a 2-year period. After that we should be able to drop back to an approximate budget that we are currently requesting.

GOVERNMENT LOSSES FROM ILLEGAL REDISPOSALS OF PROPERTY

Mr. BUSBEY. On page 4 you mention 2 cases in which you have recovered $10,500 to the account of the Government. Do you have reason to believe that the Government is losing much money by not having adequate compliance in this field?

Mr. LUND. Yes, I do, especially on all the old cases where we have not had proper documentation such as we now have. We have

changed the old procedure, and now have an application where the donee makes a certification, and the donor, the administrative officer of the State, and the State agreement, on one signed copy.

I think if we can clean up our old cases we would do the type of administrative job I feel the Government should do.

Mr. BUSBEY. For fiscal year 1954 you are asking for $255,000, which is an increase of $90,000 over the 1953 appropriation.

Mr. LUND. Yes, sir.

1954 ESTIMATE OF COMPLIANCE WORK EXPENDITURES AND COLLECTIONS

Mr. BUSBEY. How much of those funds would be spent on compliance work such as we have been discussing in connection with your general statement?

Mr. LUND. I hope to put in one compliance officer in each major region. We would put a compliance officer in 5 or 6 regions who would do nothing but compliance work. He would do some incidental work if he found the time, but that would be his main work.

Mr. STEPHENS. You still have not answered his question. How much of the $255,000 would be spent on compliance work?

Mr. LUND. It would be 5 GS–11 men and the travel expenses. I can work that out.

Mr. BUSBEY. Supply it for the record at this point.

(The information is as follows:)

We propose to spend between $85,000 and $90,000 of the increased request in the budget for this year for compliance work. As stated earlier in my testimony, we expect to employ 5 or 6 chief compliance officers for the field and a number of assistant compliance officers together with supporting clerical personnel, total of 10 persons for the field work.

Mr. BUSBEY. Also, supply for the record an estimate of how much each dollar spent on compliance work would return to the Federal Treasury in dollars.

Mr. LUND. Yes, sir.

(The information requested follows:)

If our requested budget is allowed and we spend from $85,000 to $90,000 on compliance work, it is expected that this staff would return in revenue to the United States Treasury about five times this amount, or $450,000. If the staff is further expanded, it is anticipated that for the next several years it would be possible to return approximately five times the amount expended for compliance work.

Mr. STEPHENS. Mr. Chairman, there is one point in connection with compliance I would like to bring out. I have noticed that all institutions in all States do not have to be coerced. They write and say they are faced with a certain situation, and they want to do what is right. I know we had one case where it took a man-year to clear up a situation, and there was no desire on the part of the State not to carry out its obligation, but somebody has to look after these cases and process them and see that the payments are made to the Federal Government.

REQUESTS FOR FUNDS FOR COMPLIANCE WORK

Mr. BUSBEY. Have you tried to get more funds approved by the Bureau of the Budget just for compliance work?

Mr. LUND. No. The situation has been reversed. We make the request in relation to our established ceiling. The Bureau of the Budget has not cut our ceiling request. They have put the emphasis on more compliance work. But when one had to make distribution of property to keep the State agencies alive, and had to pick up all this property for Army services, plus running the "hot" cases of compliance, one had no more time to spend on anything with the staff we had. It just cannot be done.

Mr. BUSBEY. Why has not the Department allocated more of its budget ceiling to compliance work?

Mr. LUND. Well, sir; I cannot answer that. I do not know.

Mr. STEPHENS. Mr. Chairman, in approving the estimate of $255,000 and the increase you mentioned a moment ago, the budget specifically states that the increase is to strengthen compliance activities. In the committee print and in the President's budget that statement was included, that the increase was to strengthen compliance activities.

REVOLVING FUND PROPOSAL

Mr. LUND. We have made several other proposals, Mr. Chairman. One is that there be established a revolving fund out of receipts for a short period of time in order to get adequate funds to get ourselves liquidated. I think that matter is under discussion and consideration at the Budget. I am not sure where it is. We did prepare such a suggested proposal.

Mr. STEPHENS. In the rush to get the budget out and revised, that was thrown out. It was discussed that with the receipts as they were the Congress could, under certain appropriation language, eliminate an appropriation and make current receipts available, within limitations, for the operation of this program without the necessity of an appropriation. If the Congress or this committee should decide to make this self-sustaining and operated from receipts, the language would have to make current receipts available, part of which are still in a contingent fund, or an appropriation would have to be made until the receipts came in.

Mr. BUSBEY. That would appear to me to be something like paying a policeman out of receipts, and I do not know if that would be good or not.

Mr. STEPHENS. The committee could provide some language that this could be financed to the extent of $200,000 or $300,000 from receipts, the balance of the receipts to go into the Treasury. I do not think Mr. Lund's office ever contemplated unlimited use of receipts.

Mr. LUND. No. The purpose was to get ways and means of obtaining necessary funds to do what we thought was a good job for the Government.

CONSEQUENCES OF DELAYING COMPLIANCE INVESTIGATIONS

Mr. BUSBEY. What effect does the delaying of these compliance cases have on your bringing them to a proper conclusion?

Mr. LUND. It has considerable effect, especially those cases that go to a legal conclusion. You probably saw in a national magazine recently an account of a case where there was an airplane just taken and flown off the field. We had to trail it all over the country. Finally we did place a hold order on it. When it goes into litigation we may have care and custody. That costs money. The longer these things are delayed, the more it costs. One plane in Oklahoma that cost about $25,000 went through seven channels. We caught it at an airport in Miami ready to be flown out of the country. We had it picked up at that point, and we had to go back to establish who had first made the illegal sale. In some of these cases, unless there was a criminal intent, we have not prosecuted. It just does not pay.

LEGAL AUTHORITY FOR SURPLUS PROPERTY DISPOSAL PROGRAM

Mr. BUSBEY. Will you have prepared for the record a brief summary of the law under which this program operates and insert it in the record at this point?

Mr. LUND. Yes, sir.

(The information is as follows:)

BRIEF SUMMARY OF THE LAW UNDER WHICH THE SURPLUS PROPERTY PROGRAM FUNCTIONS AS REQUESTED BY THE COMMITTEE

The Federal Property and Administrative Services Act of 1949, as amended (Public Law 152, 81st Cong.) approved June 30, 1949, authorizes the Secretary of the Department of Health, Education, and Welfare to allocate Federal surplus personal property to tax-supported or tax-exempt medical institutions, hospitals, clinics, health centers, school systems, schools, colleges, and universities to be used for health or educational purposes. Following the allocation the Administrator of General Services Administration is authorized to make the donation of such property. The law also provides that the donation may be made to State departments of education or health for distribution to the institutions or where another agency is designated by State law transfers are made to that agency for distribution within the State.

Subject to the disapproval of the Administrator of General Services Administration the Secretary is also authorized to transfer surplus real property for health or educational purposes to the States and other political subdivisions and tax-supported or tax-exempt health or educational institutions.

Under the third function delegated to this Department, the Secretary is authorized and directed to determine and enforce compliance with the terms and conditions contained in any instrument by which transfers of surplus property were made for health or educational purposes under the Surplus Property Act of 1944, as amended, and pursuant to Public Law 152. Under this authority the Secretary may reform, correct, or amend any such transfer instrument, grant releases from any of the terms and conditions and convey or quitclaim any right or interest reserved to the United States if a determination is made that the property so transferred no longer serves the purpose for which transferred or if such release will not prevent accomplishment of the purpose for which such property was so transferred. Compliance actions are subject to 30-day right of disapproval by the Administrator of General Services Administration.

Mr. BUSBEY. Mr. Fogarty.

IMPORTANCE OF CARRYING ON ADEQUATE PROGRAM

Mr. FOGARTY. I think that the record speaks for itself. Mr. Lund has done a good job in this surplus property disposal unit over the past years. I have thought in the past that he should have had more money to operate with. I think the trouble started 2 years ago on the House floor when an amendment was made to this appropriation bill and cut out—was it a couple hundred thousand?

Mr. LUND. Yes; from $330,000 to $90,000.

Mr. FOGARTY. That was 2 years ago. The statement was made that the war was over and we should be getting out of this business, and that in another year there would be no surplus property. I remember opposing the amendment on the floor, but in the guise of economy the amendment was carried, and the Government has lost money.

Mr. LUND. That is correct.

Mr. FOGARTY. That is where the harm was done, 2 years ago. If you had been operating under a budget of, say, $350,000 over the past 2 years, you could have been doing a decent job of administering this program.

Mr. LUND. That is right.

Mr. FOGARTY. And the Federal Treasury would have more money than it has.

Mr. LUND. That is right.

Mr. FOGARTY. I remember that day a Member got up on the floor and said that he had it on good authority this was the end of surplus property and we should save money by cutting the appropriation. I thought I did a fair job in answering him, but Members were not interested in the facts and were willing to vote for any cut. So the Congress is responsible in this particular instance. We are always talking about economy, but they did not know which side the economy was on when this cut was voted.

I think you should have more money, because the facts are there, and the report you have given us for fiscal year 1953 is a positive one. It is one that has shown a profit for the Federal Government?

Mr. LUND. Yes, sir.

Mr. FOGARTY. If we do not have an agency like this we will lose a lot of money for the Federal Government.

Mr. LUND. We will come in for some criticism from the investigation now going on by the Congress, these are all old cases; they are cases that we have inherited, and we cannot clean them up unless we have funds.

Mr. FOGARTY. I think I said on the floor of the House 2 years ago that rather than cut you down to $92,000 the Members should be men enough to cut it out entirely because you could not operate with that amount of money and do a decent job. I think that if Members of Congress want to do something about economy, this is one place where, if they gave you more money, they could get more money into the Treasury. Is that so?

Mr. LUND. Yes, sir, for a couple years.

Mr. FOGARTY. I am talking about a period of 2 years. You said with an appropriation of about $550,000 for 2 years you could clean up this backlog.

Mr. LUND. That is correct.

Mr. FOGARTY. And get this money in the Treasury where it belongs.

Mr. LUND. Yes, sir.

Mr. FOGARTY. That is all, Mr. Chairman.

Mr. BUSBEY. Thank you, Mr. Lund.

Mr. LUND. Thank you.

TUESDAY, APRIL 14, 1953.

OFFICE OF THE GENERAL COUNSEL

WITNESSES

PARKE M. BANTA, GENERAL COUNSEL
ALANSON W. WILLCOX, ASSISTANT TO THE GENERAL COUNSEL
M. A. STEPHENS, BUDGET OFFICER

SALARIES AND EXPENSES

Amounts available for obligation

	1952 actual	1953 estimate	1954 estimate
Appropriation or estimate		$387,500	$455,000
Reimbursement from non-Federal sources		387,500	405,000
Reimbursement from other accounts		31,700	25,000
Obligations incurred		806,700	885,000
Comparative transfer from:			
"Salaries, Office of the General Counsel, Office of the Administrator, Federal Security Agency"	$828,748		
"Salaries and expenses, division of service operations, Office of the Administrator, Federal Security Agency"	40,730		
"Operating expenses, National Institutes of Health, Public Health Service"		3,000	
"Salaries, expenses, and grants, National Cancer Institute, Public Health Service"		2,800	
"Mental health activities, Public Health Service"		2,000	
"Salaries, expenses, and grants, National Heart Institute, Public Health Service"		2,000	
"Surplus property disposal, Office of the Administrator, Federal Security Agency"		4,280	
"Salaries and expenses, Saint Elizabeths Hospital"		3,520	
Total obligations	869,478	824,300	885,000

NOTE.—Reimbursements from non-Federal sources above are pursuant to the Labor-Federal Security Appropriation Act, 1954.

Obligations by activities

Description	1952 actual	1953 estimate	1954 estimate
1. Supervisory and general legal services	$217,578	$176,649	$183,399
2. Departmental program services:			
(a) Public health	57,940	57,677	73,197
(b) Food and drug	153,402	131,339	152,469
(c) Old-age and survivors insurance	130,572	148,817	164,817
(d) Welfare and education	74,478	66,082	67,382
3. Regional and field	235,508	243,736	243,736
Total obligations	869,478	824,300	885,000

Obligations by objects

Object classification	1952 actual	1953 estimate	1954 estimate
Total number of permanent positions	142	130	142
Average number of all employees	133	122	130
Average salaries and grades:			
General schedule grades:			
Average salary	$6,156	$6,290	$6,149
Average grade	GS–9.2	GS–9.1	GS–9.0
01 Personal services:			
Permanent positions	$825,561	$782,814	$841,044
Regular pay in excess of 52-week base	3,187	2,956	2,956
Total personal services	828,748	785,770	844,000
02 Travel	15,158	15,000	15,000
03 Transportation of things	425	500	500
04 Communication services	5,282	4,235	4,235
06 Printing and reproduction	2,889	2,000	2,000
07 Other contractual services	1,725	1,500	1,500
08 Supplies and materials	4,594	4,100	4,590
09 Equipment	10,657	10,695	12,675
15 Taxes and assessments		500	500
Total obligations	869,478	824,300	885,000

Analysis of expenditures

	1952 actual	1953 estimate	1954 estimate
Unliquidated obligations, start of year			$39,420
Obligations incurred during the year		$806,700	885,000
		806,700	924,420
Deduct:			
Reimbursable obligations		419,200	430,000
Unliquidated obligations, end of year		39,420	45,500
Total expenditures		348,080	448,920
Expenditures are distributed as follows:			
Out of current authorizations		348,080	409,500
Out of prior authorizations			39,420

Mr. BUSBEY. We have for consideration the appropriation request for the Office of General Counsel of the Department of Health, Education, and Welfare.

I want to welcome you to the committee room, Mr. Banta. I am sure the members of the committee remember Mr. Banta from the period when he was a Member of the House of Representatives from the Eighth Congressional District of the great State of Missouri. Personally I am glad to see you back in Washington.

Mr. Banta has just come into the newly created Department of Health, Education, and Welfare as General Counsel, and has had just about enough time, I presume, to find out where his office is. We do not expect you to justify the request, Mr. Banta, but I thought perhaps you might have just a short statement you would like to make to the committee, and then we will ask Mr. Willcox to testify.

Mr. BANTA. Thank you very much, Mr. Chairman.

GENERAL STATEMENT

I became General Counsel of the Department of Health, Education, and Welfare at the time of its creation on April 11, which was last Saturday. I have not had time to do more than take a look at the

general outlines of the job and of the estimate that is before your committee. I have been impressed with both the magnitude and diversity of the responsibilities involved in connection with all the legal work of this new executive department.

I am sure you know that my knowledge of the budget for the office of General Counsel as it is now presented, is very limited. Mr. Willcox, the former General Counsel of the Federal Security Agency, is here, and I want him to tell you what our requirements are, based upon his experience.

I want to say, however, that what I ask, and all I ask for, is sufficient funds to enable us to do a good job for this new Department. I cannot of my own knowledge translate this general principle into terms of dollars and cents, because I have not yet seen enough of the workload in the office. I can only assure this committee of my intention to do the best job I can with the funds which are to be made available.

Mr. BUSBEY. Thank you, Mr. Banta.

Mr. Willcox?

GENERAL STATEMENT

Mr. WILLCOX. Mr. Chairman and members of the committee, the Department of Health, Education, and Welfare comes into being with a smaller legal staff than the Federal Security Agency had at any time in its history. I sincerely hope that this committee and the Congress will allow the increases that have been recommended, in order that the Department may have the advantage of more adequate service at certain points where it is critically needed.

APPROPRIATION REQUEST

The appropriation requested is $455,000, together with $405,000 to be transferred from the old-age and survivors insurance trust fund and $25,000 from the fees collected for certification services, Food and Drug Administration. The requested increases amount to $60,700 as follows: an increase of $16,000 or 4 positions, in old-age and survivors insurance funds; $21,130, or 5 positions, for food and drug work; $15,520, or 3½ positions, for Public Health Service and St. Elizabeths Hospital work, $4,280; or one-half position, for surplus property work; and $3,770 for several minor items. Of the total increase requested, $43,200 is in our regular appropriation and $17,500 in the old-age and survivors insurance transfer.

Although the legal work of the Department is, as I believe it ought to be, centralized in the Office of the Secretary, a great part of it is attributable to one or other of the particular programs for which the Department is responsible. Thus, of the 91 attorneys asked for in fiscal year 1954, 45 are for legal work of the old-age and survivors insurance system, 20 for food and drug work, 8 for Public Health Service work and so on. There are several units of the Department, such as the Bureau of Public Assistance, to which only one attorney can be assigned full time.

Let me turn now to the specific increases requested:

OASI LEGAL WORK

The rising old-age and survivors insurance workload of our office represents chiefly the emergence of several basic problems inherent in the 1950 and 1952 amendments of the Social Security Act, and also in some part the mounting volume of litigation to review the determinations of individual benefit claims. As indicated more fully in our written justifications, such matters as the determination of "substantial services" in connection with self-employment earnings, the interrelationships of old-age and survivors insurance with other benefit systems, the constantly expanding agreements for coverage of State and local public employees, and the interpretation of some of the difficult definitions demand comprehensive and continuing legal analysis. As a result of liberalized coverage provisions and benefit amounts, moreover, new court actions to review benefit decisions have risen from 31 in the fiscal year 1952 to 34 for the first 9 months of fiscal 1953, or an annual rate of 45. Each of these cases requires the preparation of extensive materials for the use of the Department of Justice in order that the court may be fully informed of the legal reasons for the administrative decision, and to guard against troublesome court decisions based on inadequate understanding of this complex law. Even if there is no further increase in the rate at which new cases come in, the impact of the increase in workload will be delayed by the delay in reaching cases in court, and will be increasingly felt in fiscal 1954.

FOOD AND DRUG DIVISION

In the case of our Food and Drug Division, the requested increase is simply for the purpose of enabling us to keep abreast of the enforcement work of the Food and Drug Administration. It is obviously inefficient to develop enforcement cases, merely to have them pile up in our office. The most strenuous efforts of the present staff have not succeeded in preventing the accumulation of serious backlogs.

We have also been unable to keep pace with the food standards work of the Administration. The unavailability of attorneys to prepare for and participate in the hearings required by law, and to work on the resulting records (often very extensive) have slowed down seriously the whole administrative program in this area.

USE OF NEW DISCOVERY PROCEDURE

Finally, we are convinced that a strengthening of our staff will lead to savings through intensive use of the new discovery procedure. A sampling in a few cases has indicated that the need for trial, costing from $1,000 up to $40,000 or more per case, can be eliminated in at least one-third of our contested cases. Extension of this experiment, which the requested increase would make possible in some degree, promises substantial savings.

PUBLIC HEALTH DIVISION

Our Public Health Division consists at present of only 5½ attorneys to perform all the legal work for the large and diverse operations of the Public Health Service and St. Elizabeths Hospital. We are

asking for 2½ more. The increase would be distributed over several areas of work.

The speed of modern travel and increased foreign travel and trade create new dangers of the spread of epidemic diseases which call for adaptation of foreign quarantine regulations in the light of latest scientific knowledge; similar factors affect the field of interstate regulation. In the field of research grants the problem of preserving the legal availability of patentable inventions arising in the course of the research is being worked out with universities and other research institutions. In the field of Federal-State relations there is an unmet demand for technical legal advice in utilizing recently developed scientific techniques and procedures in the preparation and enforcement of public health statutes, ordinances, and regulations. Examples are the fields of water-pollution control, vital statistics, hospitalization of the mentally ill, milk and food control, shellfish sanitation, municipal and rural sanitation, control of trichinosis through treating of garbage fed to swine. The recent identification of more than 100 potential sources of interstate pollution has raised pressing legal problems under the Warer Pollution Control Act. The hospital survey and construction program calls for legal advice both on specific projects and on general problems arising as the program matures.

Our Public Health Division also advises on the accountability of grantees for expenditure of Federal funds, and of matching funds where required under the numerous grant programs of the Public Health Service—also, on the liability of foreign shipowners and certain categories of patients (including their estates) under various statutory provisions applicable to the Service and to St. Elizabeths Hospital. At the present time, we are pressing a claim of $10,000 against a foreign shipowner; also a claim of $6,000 against the estate of a deceased patient at St. Elizabeths Hospital.

I will not take your time to discuss in detail the other items reflected in our budget estimate, as set forth in our written justification. There is one other point, however, on which I wish to say a few words.

RECENT REORGANIZATION OF OFFICE

Since the hearings before your committee last year, there has been a decision of the Civil Service Commission Board of Appeals and Review, to the effect that the job of the head of one of our divisions is properly classified at GS–15, the job of his chief assistant at GS–14, and the jobs of his branch chiefs at GS–13. Since that decision was rendered, however, there has been an important reorganization of the office. The number of divisions has been reduced from 6 to 5, and the number of departmental jobs in grades GS–15, GS–14, and GS–13 has been reduced from 30 to 24. Mr. Banta will, of course, wish to study the organization of the office and its grade structure, and I must obviously leave to him any further changes that he may find needed.

In turning over the responsibility to him, I am leaving to him a staff, numerically small, but I believe of exceptional caliber. Our most serious lack is of junior supporting staff. You will note that the requested new positions are, except for one at GS–11, all in grades 9 and 7. If these increases are granted, the staff will be better balanced than it has been in some years.

In closing my last presentation to this committee I should like to record my earnest belief that in the functions that have been performed by the Federal Security Agency, and are now to be carried forward by the new Department, a strong and effective legal staff is essential to good administration. I am confident that Mr. Banta will put the increases requested to the best possible use.

BUDGET REQUEST COMPARED TO 1953 APPROPRIATION

Mr. BUSBEY. The request, Mr. Willcox, is for $885,000 and 142 positions?

Mr. WILLCOX. That is right, sir.

Mr. BUSBEY. Or an increase of $60,700 and 12 positions over what you have for the current year; is that right?

Mr. WILLCOX. That is right.

SIGNIFICANCE OF PROPOSED LEGISLATIVE CHANGES

Mr. BUSBEY. During the last few years there have been many changes in the laws which the agency has operated under; is that not correct?

Mr. WILLCOX. That is true, sir; yes.

Mr. BUSBEY. What changes of significance are now being given serious consideration by the Congress?

Mr. WILLCOX. I am not sure I can answer that question, Mr. Chairman. There are many bills in the Congress. I cannot purport to say which ones will be given serious consideration, frankly. I can name certain bills I think are likely to receive it.

Mr. BUSBEY. Taking it all in all, it does not appear that in total the changes will be of too great significance, does it?

Mr. WILLCOX. I do not know how great the change will be. As you know, there are proposed studies to be carried forward in various areas in which the Department is concerned. What those will lead to and when they may lead to legislation, of course, I have no idea.

LEVEL OF PRESENT OPERATIONS

Mr. BUSBEY. Are you getting by fairly well for fiscal year 1953?

Mr. WILLCOX. I would not say that, Mr. Chairman. Frankly, I think we are leaving a good many things undone that ought to be done. There is a considerable backlog in the Food and Drug Division. Elsewhere it takes a form not so much of a backlog as, frankly, work not done, and many things done in the agency without legal advice where we feel, and I think generally speaking the bureaus feel, that they ought to have legal advice.

CASELOAD OF FOOD AND DRUG DIVISION

Mr. BUSBEY. You consider that the cases handled by the Food and Drug Division should be given closer and more intimate attention, rather than considering present cases as a backlog?

Mr. WILLCOX. Well, it is a combined problem, Mr. Chairman. On the actual enforcement cases there is a considerable backlog, particularly in the criminal cases. There are several important cases that the Administration would like to initiate as enforcement

cases, which it has held off initiating because of lack of attorney time to work on the cases.

In the regulatory program, in the food standards primarily, again, the Administration has held off initiating hearings for the framing of regulations which they feel ought to be done, which they are ready to do, because we do not have the attorneys to work on them.

BACKLOG

Mr. BUSBEY. How does this current backlog of food and drug cases compare with a year ago and 2 years ago?

Mr. WILLCOX. It is worse now than it was then. I do not have the backlog figures. Two years ago I think we did not have any backlog. It has been accumulating gradually since then.

Mr. BUSBEY. What has brought that condition about?

Mr. WILLCOX. A smaller staff, I think. I am not sure whether the Food and Drug Administration has been generating cases more rapidly or not. Of course, they are always trying to keep their work up to as high a pitch as they can. I think it is primarily the reduction of staff.

EFFECT OF PREVIOUS APPROPRIATIONS

Mr. FOGARTY. Your office was cut quite a bit 2 or 3 years ago, was it not?

Mr. WILLCOX. Yes, it was, Mr. Fogarty. It has been progressively cut each of the last several years.

Mr. FOGARTY. It has been cut almost every year.

Mr. WILLCOX. Yes.

Mr. FOGARTY. As a result you have not been able to keep up with all the responsibilities which have been imposed on you since the Reorganization Act of 6 or 7 years ago, when all of the legal offices were merged into 1 central office.

Mr. WILLCOX. We had some small increases once or twice, but the reductions—and they have been steady reductions in the last several years—have more than wiped those out and left us, as I said, with the smallest staff we have ever had.

Mr. FOGARTY. That is all, Mr. Chairman.

Mr. BUSBEY. Thank you very much, Mr. Willcox.

TUESDAY, APRIL 14, 1953.

Mr. BUSBEY. Mr. Stephens, there are 1 or 2 things I think we ought to discuss with you before we adjourn.

Mr. STEPHENS. All right, sir.

WORKING CAPITAL FUND

Mr. BUSBEY. First is the language requested on page 252 of the committee print, at the bottom of the page, dealing with the working capital fund:

The working capital fund established in the Federal Security Appropriation Act, 1953, shall hereafter be available for financing such central services as the Administrator determines may be performed more advantageously on a reimbursable basis.

Now, of course, "Administrator" will have to be changed to "Secretary." But what is the explanation of the need for the language?

Mr. STEPHENS. That, Mr. Chairman, was put in there in order to continue to expand that working capital fund, which this committee gave us, I mean the operation of that fund, to cover some other services in that agency which should have been covered at the outset. The language in the original establishment of that fund was limited to three things: Central reproduction, central supply, and central tabulating in the operation of the agency. A number of other central services being possible, like mail distribution, messenger service, the distribution of legislative materials, and so on. There are half a dozen items that could be bought at that place centrally. There are all the congressional materials, for instance, which could be sold to the units just like we sell the mimeograph paper, letterheads, and other supplies.

That was put in merely to overcome this limitation.

Just this week, Mr. Chairman, a number of men from the General Accounting Office came into my office and wanted to be sure that you had a proper explanation of this, because they are of the opinion in the General Accounting Office that these other services should be done in that working capital fund exactly as we do the tabulating and the supply. There are little things that come up from time to time. There have been a lot of items discussed.

There are some library services. The committee set the pattern on the library service, so we have not, nor has the General Accounting Office, pushed us about centralizing that or putting the services received from the library in the working capital fund. But I think there are many more than these three services.

We have gone a long way on the mail distribution. They used to drive a truck into the basement, with a pouch of mail for Public Assistance, another for Public Health, and another for Education. That all goes to the central mail room and is distributed. But we feel, and I think the program bureaus feel, that they should pay their part on a service-rendered basis for such items as messenger service and mail service.

Then there is one other item I did not mention. Frequently there is a labor item, such as moving an office, where the working capital fund could take it into account, and they could bill for that just like they bill for reproduction, tabulation, and any other miscellaneous supplies.

This would cover any of the things like records-management labor services and so on. Frequently the Records Management Section finds that you do not need any new filing cabinets; all you have to do is to get in and see what goes to Archives, and take the cabinets and rotate them. In that connection, we have not bought a filing cabinet in the agency in 2 years, just by good records management. What goes out is 5 years old, and the cabinet moves up and starts all over again.

That, Mr. Chairman, is not intended in any way to take any of the functions away from anybody else. It is simply to do a number of other things more than the three specified up there in the original language, as it was drawn.

In fact, our submission of that original language which went to the Bureau of the Budget was a little bit broader. I am pretty sure that was written by them or by this committee. We had it broad enough at the outset to do that. Mr. Miles was in the Bureau of the Budget when this thing went through, I think. I am not sure whether he remembers it or not.

Mr. MILES. No, I do not.

STATEMENT OF ADMINISTRATIVE EXPENSES, FISCAL YEAR 1953

Mr. BUSBEY. Mr. Stephens, I believe that you were required by the Bureau of the Budget to make up a so-called Summary Distribution of Personal Services for each appropriation. I would appreciate it if you would, using that report as a base, prepare a statement on administrative expenses for the record. What I would like is a breakdown of these expenses for fiscal year 1953 by man-years and dollars for each constituent agency, with a total for the Department, showing the amount spent for personnel, fiscal, property management, budget, organization and methods, and an all other category for the remaining administrative expenses. Since there is sometimes argument over whether or not executive direction should be considered a part of administrative expenses, you might put in a separate line for executive direction.

Since I understand that the Bureau of the Budget report does not include costs other than personal services, you may include an estimate for such expenses or not as you see fit. They would amount to a small percentage of administrative expenses and would not be worth spending a lot of time to get accurately. Of course, note on the statement whether or not they are included.

Mr. STEPHENS. Yes, sir. That is for the entire agency?

Mr. BUSBEY. Yes.

(The information is as follows:)

Summary distribution of administrative personal services, fiscal year 1953

	Food and Drug Administration	Freedmen's Hospital	Office of Education	Office of Vocational Rehabilitation	Public Health Service	Saint Elizabeths Hospital	Social Security Administration	Office of the Secretary	Total, Department of Health, Education, and Welfare
Personnel:									
Salaries	$34,683	$33,753	$29,814	$6,700	$809,054	$78,645	$553,190	$300,372	$1,846,211
Man-years	7.9	8.0	6.0	1.1	163.2	18.0	121.3	[1] 64.9	390.4
Fiscal activities:									
Salaries	$83,752	$62,811	$106,051	$14,183	$1,528,341	$110,295	$330,507	$395,218	$2,631,158
Man-years	21.8	17.0	27.5	3.4	398.3	28.0	85.4	[2] 99.8	681.2
Property management:									
Salaries	$33,985	$42,431	----------	$9,849	$1,470,951	$104,810	$703,017	$116,875	$2,481,918
Man-years	9.5	12.0	----------	2.2	374.3	29.0	225.5	[3] 34.5	687.0
Budget:									
Salaries	$10,431	$9,225	$29,813	$8,334	$107,742	$9,650	$67,375	$69,084	$311,654
Man-years	2.0	2.0	5.5	1.4	19.4	1.8	12.8	9.8	54.7
Organization and methods:									
Salaries	$7,040	----------	$10,227	$836	$206,665	$6,030	$380,194	$63,833	$674,825
Man-years	1.0	----------	1.5	0.1	42.6	1.2	73.7	9.0	129.1
All other administrative expenses:									
Salaries	$169,677	$61,848	$49,819	$24,037	$1,514,388	$45,045	$4,020,963	$1,083,774	$6,969,551
Man-years	45.8	15.5	12.5	5.8	413.6	8.0	975.1	[4] 293.8	1,770.1
Total administrative expenses:									
Salaries	$339,568	$210,068	$225,724	$63,939	$5,637,141	$354,475	$6,055,246	$2,029,156	$14,915,317
Man-years	88.0	54.5	53.0	14.0	1,411.4	86.0	1,493.8	511.8	3,712.5
Executive direction:									
Salaries	$33,809	$26,371	$49,032	$36,862	$294,754	$40,160	$183,383	$154,327	$818,698
Man-years	4.0	4.0	7.0	5.7	38.0	5.0	26.5	19.0	109.2
Total, personal services for administrative services and executive direction:									
Salaries	$373,377	$236,439	$274,756	$100,801	$5,931,895	$394,635	$6,238,629	$2,183,483	$15,734,015
Man-years	92.0	58.5	60.0	19.7	1,449.4	91.0	1,520.3	[5] 530.8	3,821.7

[1] Includes 40.0 for regional offices.
[2] Includes 80.3 for regional offices.
[3] Includes 13.5 for regional offices.
[4] Includes 109.8 for regional offices.
[5] Includes 111.0 in the working capital fund.

Unexpended Balances

Mr. Busbey. There is just one other thing I would like to take up, and that is to get some more information on some of your unexpended balances.

I have registered some complaints, as we have gone through the hearings, about requests for appropriations to remain available until expended. I have suspected that balances of such appropriations are often not offered for rescission when they should be. There are a few balances under this type of appropriation that I would like some more information about.

GRANTS, WATER-POLLUTION CONTROL

There is one that appears on page 240 of the budget and is entitled "Grants to States, Municipalities, Etc., for Plan Preparation, Water-Pollution Control, Public Health Service." This seems to be a good example of what I was afraid happened under this type of appropriation. The budget shows that you carried forward $200,000 from 1951 to 1952; the same amount from 1952 to 1953; you are still carrying it forward to 1954; and it even indicates that you will carry it on to 1955.

Why was this $200,000 not recommended for rescission 2 or 3 years ago?

Mr. Stephens. You would like me to comment on that, Mr. Chairman?

Mr. Busbey. Yes.

Mr. Stephens. Actually what happened on that was that at the time it first became a balance or a carryover there was quite a bit of feeling that Congress might, if the emergency were over, go ahead and try to do something about these plans and so forth. Now, as a matter of fact, when the emergency came along, and in order not to let that money be spent, it was actually frozen and impounded. It could not be spent. Public Health could not spend that money now if they wanted to, nor could we, without a hearing in the Bureau of the Budget.

Just within the last 2 or 3 weeks that item has been one of the moot items, and the Budget would have included it in this letter—you see the copy of Mr. Dodge's letter, about the two rescission items—but they were of the opinion, and many people were of the opinion, that we could actually send a form to Treasury and rescind it by administrative action by just telling Treasury to put it back into "Miscellaneous receipts."

That is one of the cases I have been trying to get around to, Mr. Willcox, to find out about. My own fiscal people tell me I can do that, and the Budget people tell me I can do that, and we have done the next nearest thing to that, in that it is impounded. We have no intention of taking it out of impoundment.

I have been trying to get Public Health to write me a memorandum and tell me they do not want it any more. In the absence of such a memorandum, I think we will take that administrative action anyway.

If the chairman decided to rescind it in the same action with this other, you would not hear any objection down there. We thought we could do it administratively, and I am not so sure but what we can just turn it back into the Treasury.

Mr. BUSBEY. Could not that $200,000 be rescinded by appropriation language?

Mr. STEPHENS. Yes, sir. Normally that is the way that type of appropriation is gotten off the books—by a rescission in the appropriation language.

Mr. BUSBEY. Would you submit to the committee what, in your opinion, would be the proper appropriation language to rescind that $200,000.

Mr. STEPHENS. Yes, sir.

DEFENSE COMMUNITY FACILITIES AND SERVICES

Mr. BUSBEY. I notice on page 255 of the budget that you still have a sizable amount of "Defense community facilities and services" funds left, although they are all shown as being obligated. That program is being liquidated, is it not?

Mr. STEPHENS. Yes, sir. Mr. Miles can speak to that, sir.

Mr. MILES. May I speak to that, Mr. Chairman?

Mr. BUSBEY. Yes.

Mr. MILES. That program, in effect, has been wound up, except as to the business of seeing to it that the funds which are necessary to carry out the contracts which the local communities have let are made available as needed by the communities, as they construct these community facilities. In other words, all of the funds appropriated by the Congress have been obligated and we have no more active programs on the books. We are merely cleaning up the program as it was originally intended.

Mr. BUSBEY. In other words, you have no funds left?

Mr. MILES. The obligations are within a very few thousand dollars of the maximum that was authorized. I am sure it was less than $25,000 in the way of an unobligated balance, in my recollection, sir.

Mr. BUSBEY. Can you supply for the record, then, the actual amount of cash which is left?

Mr. MILES. Yes, sir, Mr. Chairman; I would be glad to. You want both the unobligated balance and the unexpended balance?

Mr. BUSBEY. Yes.

Mr. MILES. All right.

(The information is as follows:)

Unobligated balance, Mar. 31, 1953	$5,247
Unexpended balance, Mar. 31, 1953	7,241,533

Mr. BUSBEY. Specifically, for what are these funds obligated?

Mr. MILES. They are obligated for sanitary-engineering facilities and hospitals in those communities that were overburdened by defense activities. And by "sanitary-engineering facilities" I mean sewage-disposal plants and water-purification plants in those small communities which were simply tremendously overburdened by defense activities.

Mr. BUSBEY. The budget shows that $2,950,000 will not be obligated until 1955.

Mr. MILES. I believe that is an expenditure figure.

Mr. BUSBEY. Yes; I meant expended.

Mr. MILES. Until 1955? I believe it is 1954.

Mr. BUSBEY. According to the budget schedules, that amount would be carried forward to 1955. I am just trying to ascertain why that is such a large amount.

Mr. MILES. I believe, Mr. Chairman, the explanation for that is in relation to the several projects, particularly additions to hospitals which are getting under way at the present time and which will not actually be completed until the end of next year. But I would like to doublecheck on that and put a statement in the record.

(The following was subsequently submitted:)

DEFENSE COMMUNITY FACILITIES AND SERVICES

Obligations and expenditures under Public Law 139

The most recent estimates of expenditures by year are:

1953	$2,000,000
1954	4,000,000
Subsequent years	1,950,000
Total funds available	7,950,000

The activities under Public Law 139, in general, can be divided into two parts: (1) Project review and approval phase, and (2) construction phase.

The Supplemental Appropriation Act, 1953, Public Law 547, approved July 15, 1952, reads "that none of the funds made available under this head shall be obligated after December 31, 1952, except for liquidation of the program." Funds are "obligated" when a project has been approved and an offer of grant, or loan, or both, as the case may be, has been made to the municipality. The last of 39 projects was approved December 29, 1952, exhausting available funds.

After approval of a project, the primary responsibility for completing the needed facilities is with the municipality, and frequently this latter phase has been very time-consuming. In virtually every case, detailed engineering design, plan preparation, land acquisition, advertisement for bids, and award of contracts all had to be done following approval of project and obligation of funds. Payments are made from Federal funds only as expenditures are made by the municipalities. The attached table (which shows the start and completion dates of all the projects) indicates that, as of June 30, 1953, two of the projects will have been completed. However, all but six projects will be under construction before that date. Payments will be made periodically during the construction of each project up to and including a final payment which is made after the project has been completed and an audit has been made. All but 12 of the projects will be completed before June 30, 1954, and all but 3 will be finished before the close of fiscal year 1955.

The awarding of a contract to construct the facilities does not complete the responsibility of the Federal Government. At least a moderate degree of supervision is needed to insure (1) that the needed facilities required for the defense effort are, in fact, provided and (2) that Federal funds are expended for the purposes for which they are appropriated.

Estimated construction schedule, PHS, approved projects, Public Law 139, 82d Cong.

Region	Location	Type	Estimated construction cost	1952						1953												1954												1955					
				J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
II	Lakehurst, N. J	S	$99,814										X							X																				
III	Leonardtown, Md	H	400,000										X														X													
	Jacksonville, N. C	W	147,840							A	X											X																		
	do	S	420,100							A	X												X																	
	Swansboro, N. C	W	24,784										X									X																		
	do	S	87,212										X										X																	
IV	Elizabethtown, Ky	W	184,963									X												X																
V	Lawrence, Ind	S	289,356			A	X								X																								
	Moline, Ill	H	750,000												X																				X					
	Rantoul, Ill	W&S	1,083,600									X												X																
VI	Cobb County-Marietta Water Authority, Georgia	W	1,101,340	X											X																								
	North Augusta, S. C	W	251,100		A		X												X																				
	do	S	158,800					A		X						X																								
	Blackville, S. C	S	125,000										X									X																	
	Barnwell, S. C. (3 contracts)	S	287,898				A	X								X																							
	Williston, S. C	S	138,470									X					X																							
	Aiken, S. C	W	283,500										X									X																	
	do	S	459,500												X												X												
	Augusta, Ga	W	850,000							A	X																	X							X				
	do	S	700,900									X																X											
	Allendale, S. C	S	164,640												X								X																
	Orangeburg, S. C	H	500,000												X													X							X				
	Key West, Fla	S	863,510										X											X															
	Ozark, Ala	S	500,376									X																X											
	Glennville, Ga	S	166,438										X									X																	
VII	Wichita, Kans	W	2,720,000												X																							X	X
	do	S	1,046,300												X																							X	
	Warrensburg, Mo	S	502,125												X							X																	
VIII	Copperas Cove, Tex	W&S	39,422							A	X				X																								
	Farmington, N. Mex	W	101,500									X			X																								
	Las Cruces, N. Mex	S	239,880									X							X																				
	Camden, Ark	S	123,666										X						X																				
	Killeen, Tex	G	44,500							X	X																												
IX	Mount Home, Idaho	S	81,800									X				X																							
X	San Diego, Calif	H	3,162,723								A	X																								X				
	Los Angeles County, S. C. No. 20 Calif	S	141,718					X			X																												
	Sparks, Nev	S	216,100										X												X														
	Hermiston, Oreg	H	338,000									X																X											
	Moses Lake, Wash	H	844,500													X																						X	
	Total		19,470,119																																				

NOTE

A—Indicates contract awarded. G—Garbage and refuse project. H—Hospital project. S—Sewerage project. W—Water project.

RESEARCH FACILITIES, NATIONAL INSTITUTE OF DENTAL HEALTH

Mr. BUSBEY. On page 240 of the Budget appears an item "Research facilities, National Institute of Dental Health, Public Health Service." The budget shows a carryover from 1952 of $23,466, which, in turn, is carried over from 1953 to 1954 and shows as available for carryover to 1955. Why should not this be rescinded?

Mr. STEPHENS. The obligations on that will have to be checked and, if the way this is printed is correct and there are no outstanding obligations, there is no reason why that could not be rescinded, so far as I know.

The money for dental-research facilities, as you will remember, was combined into the construction of the big clinical center. In other words, instead of building a separate building, there was, I think, a debate here that when the original law for dental facilities was passed there was a building contemplated, but in building the big clinical center that was combined into that building. And this is part of that fund. I have to confess this is one that got by me.

Mr. BUSBEY. If that money can be rescinded, will you also send us some suggested appropriation language to rescind the balance?

Mr. STEPHENS. Yes, sir.

SCHOOL-FACILITIES SURVEY

Mr. BUSBEY. Under the school-construction program, you received funds for a school-facilities survey. These funds have been available for 3 years now, and from page 172 of this year's hearings it appears that there is no definite plan to pay out approximately $1,380,000 of these funds by the end of this year.

Why should not all funds unexpended as of June 30, 1953, be rescinded?

Mr. STEPHENS. Mr. Chairman, the Office of Education feels the Congress intended that this survey of school construction should continue; but, since the basic law for school construction has expired or will have expired on June 30, I doubt if they would have legal authority to continue the survey activities after that time unless the law is extended.

Mr. BUSBEY. Would you draw up some suggested language to accomplish such a rescission in case the committee should decide to include it in the bill?

Mr. STEPHENS. Yes, sir. I would like to discuss that with the Office of Education, because in Mr. Grigsby's testimony he avers that the States are now moving into the final phases of this master plan. I think the law will have to be checked to see if that is legal. If it is legal, you might or might not want to rescind the money. And, not knowing what he means when he says "the States are now moving into the final phases of this master plan," for their school-facility studies, I would like to check with him.

Mr. BUSBEY. Any additional statement you or the Office of Education want to send up can be included.

Mr. STEPHENS. All right, sir.

(The information is as follows:)

The purpose of this statement is to clarify the status of the school-facilities survey pursuant to title I, Public Law 815, in its relation to title II of that act, which provides for school construction in federally affected areas.

Section 101, title I, Public Law 815, which provides for the school-facilities survey, reads, in part, as follows: "* * * there is hereby authorized to be appropriated the sum of $3 million, to remain available until expended." The 81st Congress appropriated $3 million pursuant to this authority, and the unexpended portions of that sum are still available and, according to the language of the title, will "remain available until expended" by the States and Territories in accordance with title I of the act.

Title II, Public Law 815, provides for school construction in federally affected areas. Section 205 (a) states that "No local educational agency shall be entitled to payment * * * by the formula contained in section 202 except upon application therefor submitted through * * * and filed before July 1, 1952, * * *." Section 209 (c) reads as follows: "There are hereby authorized to be appropriated for the fiscal year ending June 30, 1951, and for each of the two succeeding fiscal years, such sums as may be necessary to carry out the provisions of this title, * * *." Since these two subsections occur in title II, they pertain only to title II, and have no relationship whatever to title I.

As of April 15, 1953, all of the $3 million appropriated for the school-facilities survey under title I, except $47,200, had been allotted to the 48 States and to Alaska, Hawaii, Puerto Rico, and the Virgin Islands. The allotments to the 48 States were made on the basis of population in the age bracket 5 to 17. The allotments to Alaska, Hawaii, Puerto Rico, and the Virgin Islands were made in accordance with agreements between the Commissioner of Education and the respective Territorial educational agencies out of the $150,000 reserved by the title for these Territories and the District of Columbia. The unallotted $47,200 is available only to the District of Columbia, Alaska, Hawaii, Puerto Rico, and the Virgin Islands. The Commissioner of Education made a tentative allotment of $20,000 to the District of Columbia; but, since the District of Columbia is not currently participating in the survey, the tentative allotment was canceled. The original allotment of $8,000 to Alaska was later increased through a supplementary agreement by $800 out of the $150,000 reserved for the Territories and the District of Columbia.

As of April 15, 1953, there were 46 States (including 4 Territories defined as "States") participating in the nationwide school-facilities survey through their State educational agencies, but 2 of these States (Kansas and Nebraska) were participating in accordance with the cooperative State-Federal pattern without Federal funds. The respective amounts allotted to each State, the amounts expended during the fiscal years 1951, 1952, and 1953, and the unexpended balance as of April 15, 1953, are shown in the attached table.

Most of the unexpended balance of $883,475 from the allotments to the States participating in Federal funds will be used by these States during the fiscal years 1954 and 1955 for carrying out the second phase of the school-facilities survey pursuant to title I. Some of the unallotted sum of $47,200 will be required by the Territories to complete the survey, and some of it may yet be used by the District of Columbia, should the District decide to participate. It is expected that some of the States not now participating in Federal survey funds will remove technical difficulties and provide State matching funds in order to claim their allotments under title I. A considerable portion of unexpended balance of $448,760 allotted to such States will probably be expended during the next 2 fiscal years. Kansas and Nebraska are now conducting the school-facilities survey in accordance with the uniform pattern, but they did not apply for Federal funds under the title because of a technicality in their State laws. That technicality has now been removed by legislative act in the State of Kansas, and it is expected that Kansas will file its application soon for the completion of the survey. Thus, most of the unexpended balance of $1,379,435, as of April 15, 1953, will be expended pursuant to title I, Public Law 815, by June 30, 1955.

The first phase of the school-facilities survey is now nearing completion, and a third progress report is now being prepared to supplement the first and second reports on the first, or status phase of the survey. The second, or long-range planning phase of the school-facilities survey is now underway in the participating States. June 30, 1955, is the target date for the completion of the final phase of the survey. The various States have different problems and laws, various types of school organization, and a variation in the availability of State matching funds. Because of these conditions, it would not be advisable, at this time, to establish a definite termination date for the completion of the school-facilities survey under title I.

83——2 pt. 2——25——83303

Fiscal status of the school facilities survey pursuant to title I, Public Law 815, as of Apr. 15, 1953

State	Allotment under title I	Expended			Unexpended balance
		Fiscal year 1951	Fiscal year 1952	Fiscal year 1953	
(1)	(2)	(3)	(4)	(5)	(6)
STATES PARTICIPATING IN FEDERAL FUNDS					
Alabama	$72,800	$15,400	$27,683	$16,395	$13,322
Arizona	15,960	2,979	5,943	7,038	
Arkansas	47,600	10,907	12,948	23,745	
California	171,080	7,000	84,443	79,557	80
Colorado	24,080	850	9,578	13,652	
Connecticut	33,600	3,180	7,511	12,967	9,942
Deleware	10,000		10,000		
Florida	46,760	7,500	33,447	5,813	
Georgia	77,000	13,656	63,344		
Illinois	143,360	18,649			124,711
Indiana	74,480	7,556	45,683	14,669	6,572
Iowa	47,600	8,113	15,423	8,025	16,039
Kentucky	67,480	10,000	25,000	8,000	24,480
Louisiana	59,360	18,030	27,073	5,259	8,998
Maine	18,480	771	9,076		8,633
Maryland	38,920	9,595	9,019		20,306
Massachusetts	79,800			49,246	30,554
Michigan	122,080	5,199	27,171	24,575	65,135
Minnesota	56,280		28,140		28,140
Mississippi	55,160	6,687	17,228	8,862	22,383
Missouri [1]	72,520	12,087			60,433
Montana	11,200	291	10,909		
Nevada	10,000	667	3,605	5,728	
New Hampshire	10,000	550	9,450		
New Jersey	77,560			20,487	57,073
New Mexico	14,840	3,710	11,130		
North Carolina	93,520	14,368	24,458	17,258	37,436
North Dakota	13,440	3,440			10,000
Ohio	142,520	20,643			121,877
Oklahoma	50,400	8,400	30,110	11,890	
Oregon	28,000	3,000	10,000	10,000	5,000
Pennsylvania	195,160		139,094	36,128	19,938
Rhode Island	12,600		10,760	1,840	
South Dakota	13,160	2,475	8,242	2,443	
Tennessee	72,800	10,640	13,408	2,366	46,386
Texas	156,800	21,881	24,336	38,771	71,812
Vermont	10,000	1,524	6,276	2,200	
Washington	43,960	7,345	16,806	19,809	
West Virginia	47,040	13,603	5,210	5,581	22,646
Wisconsin	63,840		8,131	16,410	39,299
Alaska	8,800	4,125	3,875	800	
Hawaii	35,000	6,952	10,037	9,843	8,168
Puerto Rico	54,000	21,500	19,701	12,799	
Virgin Islands	5,000	521	367		4,112
Total	2,504,040	303,794	824,615	492,156	883,475
STATES NOT PARTICIPATING IN FEDERAL FUNDS					
Idaho	12,600				12,600
Kansas [2]	35,000				35,000
Nebraska [2]	24,640				24,640
New York	232,960				232,960
South Carolina	52,080				52,080
Utah	15,960				15,960
Virginia	65,520				65,520
Wyoming	10,000				10,000
District of Columbia					
Total	448,760				448,760
Unallotted [3]	47,200				47,200
Grand total	3,000,000	303,794	824,615	492,156	1,379,435

[1] Missouri applied for and received a payment; but, due to lack of State matching funds, probably will not participate and will return the payment.

[2] Participating in the survey without Federal funds.

[3] Available for supplementary allotments to Alaska, Hawaii, Puerto Rico, and the Virgin Islands; and for allotment to the District of Columbia.

HOSPITAL FACILITIES SURVEY

Mr. BUSBEY. You have about the same situation with regard to the hospital survey under the Hill-Burton Act. When were those funds first made available?

Mr. STEPHENS. The first appropriation we had was not an appropriation but contract authority in 1948 under the Hospital Construction Act. So that was the first fiscal year in which money for construction was available, and I am pretty sure the survey part of the act—I think there was 3 or 4 million dollars authorized, and part of that has been appropriated, maybe 1 or 2 million dollars. But there is still outstanding authority for another appropriation under that original authorization which has never been made.

Mr. BUSBEY. Do not you think the States have had plenty of time to accomplish this survey if they desired to do so?

Mr. STEPHENS. Yes, sir; I think they have had time. But there is one mitigating circumstance or, rather, there was. During the time the survey was supposed to go ahead, the Korean situation and the tightness of materials had a tendency to delay for at least a couple of years the final survey of their plan. Of course, that should not militate against completing the survey, whether or not the material was in hand, but the allocation of material got to be a pretty serious factor in 1950 and 1951, and I think a lot of States took the position "What is the use of doing it now? We cannot get the materials," or they had trouble raising money to build hospitals.

Mr. BUSBEY. I was under the impression that most of the States had completed their surveys.

Mr. STEPHENS. That is another one of those continuing things. The States did need money. The fact of the matter is that under the hospital construction law the Public Health Service could not allocate funds except to a State hospital authority; that is, the basis was the need for hospitals, and that, of course, resulted from some form of ad hoc survey in the States.

Mr. BUSBEY. According to the table on page 851 of this year's hearings, there was $344,919.77 of those funds unexpended as of February 28, 1953. Will you determine the maximum amount of these funds that could be recovered without stopping work actually under way and prepare suggested language to rescind such amount?

Mr. STEPHENS. Yes, sir.

Mr. BUSBEY. The committee may not decide to do so, but we would like to have it in case we decide to include it in the bill.

Mr. STEPHENS. Yes, sir. That is the survey and planning money?

CONSTRUCTION PROGRAM AT HOWARD UNIVERSITY

Mr. BUSBEY. Yes.

The next item I have is the Howard University construction program. Frankly, I have not had time to unravel the maze of information concerning the status of their contract authority, liquidation cash, obligation cash, and so forth for each of the 13 projects. I know your office has made a careful analysis of this matter, and I would appreciate it if you would advise the committee of the amount of appropriations of contract authority and the amount of appropriations of cash that could be rescinded without stopping a project on which substantial work has already begun.

And, as with the other items, please prepare for the committee, language which would accomplish the purpose of rescinding these amounts in the event the committee might decide to do so.

Mr. STEPHENS. Yes, sir. I can prepare the necessary language and furnish the figures.

In that case, I think the Secretary would like to discuss that with you, especially if you meant to go all the way, because she feels—and I think most of this committee and Congress and you, too, probably, feel—that although they have done a lot for Howard University, this is more or less a specialty in trying to build a complete medical school. A number of those buildings are directly connected with the medical school—the pharmacy building and the biology-greenhouse building—and I believe the plan to complete the premedical building.

I think your final decision will be on the matter of degree. But I will be glad to get a statement on all that and get it in a form to let the committee be the judge.

Mr. BUSBEY. I would appreciate it. What the committee will decide to do in the final analysis will not, of course, be determined until we meet in executive session to mark up the bill. But the Secretary, Mrs. Hobby, will be before our committee again before we conclude our hearings.

Mr. STEPHENS. This matter was discussed at length with the Bureau of the Budget in a Saturday session at which Mr. Miles, Mrs. Hobby, and I were present, and the question of rescissions on Howard construction came up, and the discussion went at length into the development of the medical center. And inasmuch as the Agency and the Bureau of the Budget both have complete authority to freeze the expenditure of money, what we were trying to do was to limit the spending of funds in 1954, and the Administrator immediately authorized a freeze on building not yet under way, and the Bureau of the Budget has part of the money impounded, which is an additional freeze.

At that meeting we thought we had made the wisest decision in that it did stop the spending of money for 1954 and it would give the new Secretary time to go completely into the merits of the several different projects, especially the buildings connected with the medical center, in order that she would be in a position to talk about it and make a more intelligent decision than she was prepared to do that day. And it was agreed there that all the funds except for buildings actually under way would be impounded, and they are impounded, and the Public Buildings Administration has been so advised; so no one is going to move toward building any more buildings for Howard until funds are released. Regardless of what they have in the appropriation language, either funds or contract authority, they are not going to move until the Agency releases the money.

Mr. Miles may have some further comment on that.

Mr. MILES. I would like to comment that the Secretary and the Bureau of the Budget, I think, will be in a position within a few days to make a determination with respect to the question of whether or not the various buildings which have been authorized should go forward and, if so, when. And that information will be transmitted to the committee just as quickly as that determination is made.

Mr. BUSBEY. What other balances of cash or contract authority are on your books which will not be needed?

Mr. STEPHENS. You have in the budget letter where we have requested liquidating cash of $1.9 million in 1954. Although that is the figure you have in the Dodge letter which we transmitted to you, it may change because of the decision by the Secretary which Mr. Miles was talking about with reference to construction. It may mean that we will cut it in two or take out part. And it is in that letter that we took all but $1.9 million, but there may be a change on part of that liquidating cash. But I will supply for the record any of the balances that you asked about if I find that there are any.

Mr. BUSBEY. If there are no further questions, thank you, gentlemen.

WEDNESDAY, APRIL 22, 1953.

STATEMENT OF THE SECRETARY

WITNESSES

HON. OVETA CULP HOBBY, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
JACK B. BEARDWOOD, ASSISTANT TO THE SECRETARY
PARKE M. BANTA, GENERAL COUNSEL
RUFUS E. MILES, JR., DIRECTOR OF ADMINISTRATION
M. A. STEPHENS, BUDGET OFFICER

ORGANIZATIONAL AND PERSONNEL CHANGES IN OFFICE OF THE SECRETARY

Mr. BUSBEY. The committee will come to order.

Mrs. Hobby, we have asked you to come before the committee to inform us briefly about the organizational changes in your Office as compared to the organizational structure of the Office when it was the Office of the Administrator of the Federal Security Agency. I wonder if you would tell us what changes you have made and what grades the positions created as a result of the organizational changes will be.

Secretary HOBBY. Mr. Miles and Mr. Stephens can speak up on the grades.

Gentlemen, as to the chart you have, there has been one change under the normal breakdown under the Office of Administration. In the old chart it contained "Security." In the new chart "Security" will be up in the big box immediately under the Secretary.

I do not know who wants to speak to the breakdown of grades.

USES OF REQUESTED INCREASE IN FUNDS

Mr. BUSBEY. How does this differ from the former organization of the Office? You are requesting some additional funds, more than those originally allowed for the Administrator's Office, and I assume that at least part of that increase is directly a result of the changes in organization.

Secretary HOBBY. Yes, sir. Will you pick up from there, Mr. Miles?

Mr. MILES. Mr. Chairman, whereas formerly there were authorized in the Federal Security Agency two assistant heads of the Agency, actually there never was at any one time more than one Assistant

Administrator, other than the man who served as the Deputy Administrator. In other words, there was an Assistant Administrator for Program. There was also at one time an Assistant Administrator for Defense Activities; but there never have been two Assistant Administrators of that kind at the same time. Now we will have two Assistant Secretaries, and the functions which will be grouped under those two Assistant Secretaries were given in the Secretary's testimony here before.

FUNCTIONS OF ASSISTANT SECRETARIES

The principal functions which were intended to be grouped under one Assistant Secretary were coordination of Federal-State relations which are involved in the programs of the Public Health Service, the Office of Education, the Social Security Administration, and the Office of Vocational Rehabilitation; second, the development of Department policy with respect to legislation and the numerous departmental reports which the Department is called upon to submit. These reports frequently have implications of departmentwide importance, which makes it impossible to assign them to any one of the constituent agencies. Third, liaison with private agencies. As the Secretary pointed out previously, there are a very large number of private agencies which have to be dealt with, met with, and their viewpoints understood in the operation of a Department of this kind.

Under the other Assistant Secretary it is contemplated to include the coordination of international activities with policy functions in the Office of the Secretary and operating functions in the Public Health Service, Social Security Administration, and other constituents, such as the Office of Education. There is the matter of coordination of defense planning and liaison, which you will recall I discussed previously, which also is to be grouped under the Second Assistant Secretary. There is coordination of activities concerning problems of the aging, which virtually all of the constituents of the Department are concerned with, which will also be under that Assistant Secretary.

In addition to those functions, the Department has need for considerably improved contact with Howard University, the Columbia Institution for the Deaf, and the American Printing House for the Blind. Those will be grouped under the Second Assistant Secretary.

With respect to the Office of Administration, the functions which formerly were performed in the previous Office of Administration under the Executive Assistant, plus the matter of statistical reports, planning, and so on, which I discussed previously with the committee, will be grouped under the Office of Administration. That involves an additional position of Director of Administration, and the former position of Executive Assistant is being abolished, substituting a new job of Deputy Director of Administration, in the same grade, grade 16, that the former Executive Assistant had.

APPOINTIVE AND REMOVAL AUTHORITY OF SECRETARY

Mr. BUSBEY. Mrs. Hobby, how many of the heads and other personnel of the divisions indicated on this chart have you the authority to select for yourself, and how many are there over whom you have no appointive and removal power?

Secretary HOBBY. Beginning at the top would be the Under Secretary. Then there is this Special Assistant to the Secretary on Health and Medical Affairs.

Mr. BUSBEY. Has the Under Secretary been selected yet?

Secretary HOBBY. No, sir.

Mr. BUSBEY. You expect to fill that position soon?

Secretary HOBBY. As soon as I can.

The Special Assistant to the Secretary on Health and Medical Affairs is an appointment to be made.

Security is an appointment to be made, in that box.

And there are two assistants to the Secretary, where appointments have already been made.

Mr. BUSBEY. Who are they, please?

Secretary HOBBY. Mr. Beardwood and Mrs. Spaulding.

The two Assistant Secretaries are still to be appointed. There is the Office of Administration. There is the Public Health Service, as you know——

Mr. BUSBEY. Are these three offices all vacant at the present time?

Secretary HOBBY. The two Assistant Secretaries are; yes. Mr. Miles is acting as the Chief of the Office of Administration, and will be appointed to fill that job.

The Surgeon General of the Public Health Service, as you know, has a term appointment.

The Commissioner of Education is an appointee serving at the pleasure of the President.

The Social Security Administration now is under a Presidential appointee.

Is the field service in schedule A?

Mr. STEPHENS. Yes.

Secretary HOBBY. The field service is now a schedule A job.

The position of Director of the Office of Vocational Rehabilitation has been requested to be a schedule A job.

The Food and Drug Administration is still civil service.

Now, there is a larger chart which I am sorry I do not have with me. What is the breakdown of the others, like the Office of International Relations?

Federal-State Relations under the old chart showed across here, Mr. Chairman, Federal-State Relations is now schedule A.

International Activities is now schedule A.

And the General Counsel is now schedule A.

Mr. BUSBEY. In other words, under the new Department of Health, Education, and Welfare, you will be able to select your own personnel for these top positions?

Secretary HOBBY. Yes, sir.

BUDGET REVISIONS

Mr. BUSBEY. Through the subcommittee clerk, I have asked that your budget officer, Mr. Stephens, prepare statistical statements on each of the appropriation items which has been revised. We shall put those statements in an appendix in the hearing record so that the other Members of the House may also have them available for their review.

There are several appropriation items which are significantly changed from the budget on which we held detailed hearings. I

should like the statements to include a narrative explanation of the effect of those changes. I have particularly in mind the following:

Construction of buildings for the Columbia Institution for the Deaf.

Salaries and expenses of the Office of Education.

Construction of buildings and plans and specifications for Howard University.

Each of the Public Health items that were reduced more than 5 percent.

Grants for maternal and child welfare.

That will be very helpful to the committee, to have that in the record, inasmuch as the budget has been revised since we held our hearings. I believe it is something which should be made available to all the Members of the House when we are considering the appropriations in the Committee of the Whole House.

Secretary HOBBY. So do I.

Mr. BUSBEY. Mr. Jensen?

ORGANIZATION OF DEPARTMENT

Mr. JENSEN. Mrs. Hobby, I was just going through the committee print for your Department. You have a lot of different branches. How many are there?

Secretary HOBBY. I can count them. There are 5 major constituents, Mr. Jensen, and 3 federally aided corporations, which are Howard University, the Columbia Institution for the Deaf, and the American Printing House for the Blind, and there is St. Elizabeths Hospital.

Mr. JENSEN. There are several bureaus under some of those agencies or constituents.

Secretary HOBBY. Yes.

Mr. JENSEN. It appears you have 35 or 40.

Secretary HOBBY. Under Social Security there is Public Assistance, the Federal Credit Unions, Old Age and Survivors Insurance, and the Children's Bureau.

Mr. JENSEN. All of these boards, bureaus, and agencies, I presume, have been instituted by law, have they not?

Secretary HOBBY. Yes, sir.

Mr. JENSEN. By an act of Congress?

Secretary HOBBY. Yes, sir.

Mr. JENSEN. So it would take the passage of a law to abolish some of them; would it not?

Secretary HOBBY. Yes, sir.

Mr. JENSEN. I do not suppose there is any chance of doing that, because they all apply to some very important function of Government, and are very important to people generally.

PROCESS OF BUDGET REVIEW

Up to this time, Mrs. Hobby, have you made recommendations of your own as to where the committee could reduce the budget requests herein contained, or have you left that entirely to your present bureau and agency heads?

Secretary HOBBY. I believe you were absent when I testified before as to how these budget cuts had been arrived at, Mr. Jensen.

Mr. JENSEN. It may well have been that I was attending a meeting of my other committee.

Secretary HOBBY. I did go into that specifically at that time. I reviewed the budget that you had from the previous administration with each of the constituents and with the budget officers from each of the constituents on the theory that they knew best where cuts could be accomplished to do the least damage to the program. That went forward to the Office of the Director of the Budget.

REVISED BUDGET REDUCTIONS

Mr. JENSEN. I see. Do you have an estimate as to the amount of money which will be saved by your reorganization of the program?

Secretary HOBBY. I believe Mr. Stephens has that.

Mr. STEPHENS. I have the figures, Mr. Jensen, on the reductions from the original budget.

Mr. JENSEN. That is what I mean. We have been working from the original budget.

Mr. STEPHENS. The hearings so far conducted have been on the original budget; yes, sir.

Mr. JENSEN. Yes. Go ahead.

Mr. BUSBEY. I might say, that was the reason I wanted the statements I just requested for the benefit of the committee.

Mr. JENSEN. Yes.

Mr. STEPHENS. The reduction from the original budget, on which the hearings were held, amounts to $63,383,000.

Mr. JENSEN. What was the original request?

Mr. STEPHENS. The original request was $1,786,528,761.

Mr. JENSEN. You have only recommended a reduction of $63 million?

Mr. STEPHENS. Yes.

Mr. JENSEN. What percentage is that?

Mr. STEPHENS. That amounts to 3.5 percent of the total original budget. If you will permit, sir, I would like to inject this: In that $1,786,000,000 is $1,340,000,000 of public-assistance grants.

Mr. JENSEN. Which cannot be touched?

Mr. STEPHENS. That is right. We considered those as just being uncontrollable so far as administrative discretion is concerned.

POSSIBILITY OF REDUCING GRANTS FOR PUBLIC ASSISTANCE

Mr. JENSEN. Now, let us see. I never believed in phony cuts of any kind, but is there any possibility whatever that this committee could properly reduce that item which you have just mentioned?

Mr. STEPHENS. Mr. Chairman, of course there is a possibility; and it has been done.

Mr. JENSEN. I mean without it being a phony cut?

Mr. STEPHENS. That is the attitude we took.

Mr. JENSEN. Why? Why would a cut be a phony cut? You tell us why it cannot be reduced more than you have already recommended.

There are times when you talk about uncontrollable items. I think every member of this committee will agree that there have been times during his services on these committees of Congress that heads of departments have come before the committees of Congress and said, "Any cut that you make in this appropriation request would by necessity have to be replaced at some future time." Sometimes we find that is not quite true. What I am trying to find out is this: Could a reduction be made in this item?

For what public assistance grants are these funds spent? It would be well to put it in the record.

Mr. STEPHENS. One is old age assistance. That is a category which is matched by the States.

Mr. JENSEN. All right. There are States which have not complied with congressional acts, in meeting their matching funds with the Federal Government completely, are there not?

Mr. STEPHENS. I do not know of any, Mr. Jensen, on that. They would not get the Federal funds if they did not put up their own funds.

Mr. JENSEN. What I mean is this: They have not gone the full way. They have not passed legislation in some States which would make it necessary for the Federal Government to contribute to the full amount the Federal Government has said it would contribute to the States if they match with State funds.

Has every State passed legislation which would take every dime for the States that they could get under the present law?

Mr. STEPHENS. They have, sir, unless it would be in this latest category.

Mr. JENSEN. Mr. Miles is shaking his head. Now you tell your story.

Mr. MILES. Mr. Jensen, there are, I believe, a few States—Nevada being one of them—where they have only 3 categories of the full 4 categories. I believe there is no aid to dependent children program in Nevada, if my recollection serves me correctly.

Many of the States could get more money than they are getting from the Federal Government if they appropriated more themselves and raised their own State funds.

Mr. JENSEN. That is just exactly what I am trying to find out. Now, does the request which you are making in this bill represent the full amount which could be spent if every State fully matched on a maximum basis?

BASIS OF ESTIMATE FOR PUBLIC ASSISTANCE GRANTS

Mr. MILES. No, Mr. Jensen. This is based on an estimate, Mr. Jensen, of the amounts of money which the States will appropriate or already have appropriated under their biennial system of appropriations, which by law the Federal Government must match as an obligation. The Federal Government under the law is put in a position where the amounts of money which are appropriated by the States control the amounts of money which the Federal Government must appropriate in order to match the State funds.

Mr. JENSEN. All right. Then you are saying that the amount of money you are here requesting for those purposes is the exact amount, as nearly as you can determine it?

Mr. MILES. That is right.

Mr. JENSEN. Which will be necessary to expend from the Federal Treasury in accordance with law?

Mr. MILES. Precisely; yes, sir.

Mr. JENSEN. Then you are not asking for money in anticipation of some State which has not previously taken full advantage of the Federal Government's matching requirement, doing so next year.

Mr. MILES. That is right, sir.

Mr. JENSEN. All right. Is there any other statement, Mr. Stephens?

Mr. STEPHENS. I might say this, Mr. Jensen: In that anticipation the Bureau, when it made up its original estimate for 1954, anticipating those that could come through, figured about $1,380 million. Our Agency and the Bureau of the Budget concluded that the firm figures were $1,340 million, so there was about $40 million left out because there was some anticipation in the Bureau's original estimate of $1,380 million.

We got $1 billion a year ago. This committee thought they were going to save some money and they did strenuously try. That appropriation was $1 billion. We came back for a supplemental of $340 million for 1953. That was passed by the Bureau of the Budget without much argument. It was passed by this committee and by the Senate; not that they deliberately were throwing the money away, but they knew that the money had to come from somewhere, that the figures sustained that request. So when the revised budget went back, we had just taken the last look at the 1953 figures, and the Bureau wanted $1,380,000,000. We said that we would not go over the 1953 amount, $1,340,000,000. So the figures that you are considering now are exactly the same as we have for 1953. Of course, conditions may change. There may be more unemployment, or more distress, or there may be more employment.

Mr. JENSEN. I can readily understand that with all these agencies that you have under your jurisdiction, Mrs. Hobby, you have a large job in determining the need for funds for each of them and it must be rather difficult to estimate accurately. That is all, Mr. Chairman.

FUND REQUESTS BASED ON FUTURE ECONOMIC CONDITIONS

Mr. BUDGE. Mr. Chairman, in line with what the gentleman from Iowa has stated, I noticed throughout the hearings on this bill that there appeared from time to time predictions that were made by the Department as to what economic conditions were going to be in the next 12 to 24 months. We even had one program that we were informed would level off in the year 2000. It seems to me that these economic predictions are at best rather a nebulous sort of thing.

Secretary HOBBY. It is a hazardous occupation, I can assure you.

Mr. BUDGE. I hope that speculation of that kind has been eliminated insofar as possible. That is all, Mr. Chairman.

Mr. FOGARTY. In answer to Mr. Jensen's remarks, I remember when I first came on this committee, Mr. Jensen, a very good friend of yours, Mr. Keefe, was chairman.

Mr. JENSEN. And a great fellow.

Mr. FOGARTY. He was. He made the statement every time he brought this bill on the floor that this was one of the most difficult

appropriation bills to cut that the Congress had to face. I followed him as chairman for 4 years and made practically the same statement.

PREVIOUS YEAR'S ACTION ON APPROPRIATION FOR PUBLIC ASSISTANCE

This two-billion-odd-dollar bill looks big and it is big. But, as was just said, there is $1,340,000,000 that we are bound by law to appropriate. I remember that 2 years ago we cut $50 million from this item because of changes in the Social Security Act. We thought we made a pretty heavy cut. It went over to the Senate and they cut another $100 million and the agency did not have to come back for a supplemental. So a year ago we cut this appropriation $140 million, is that right?

Mr. STEPHENS. Yes.

Mr. FOGARTY. Because we thought that the Senate might do the same thing they had done the year before and, on the basis of changes in the Social Security Act we thought this load should be lightened. However, that did not prove to be the case, and we had to come back and appropriate $340 million in a supplemental this year. There was nothing we could do about it. We can cut this any amount we want to, but they are going to have to come back for a supplemental.

Mr. JENSEN. That is exactly why I asked the question that I did.

PUBLIC HEALTH ITEMS

Mr. FOGARTY. On top of that we have all these Public Health Service items. It is pretty difficult to cut that part of this bill.

I told the Secretary last week that I think the Bureau of the Budget cut appropriation requests for Public Health too much. I do not agree with them at all on their reasoning behind these cuts. And, Mrs. Secretary, I hope that you will have an opportunity to read the hearings that took place last week before this committee. We had testimony from some of the outstanding medical men in the country, and without exception, every one of them testified to the fact that these programs will be retarded, that it would be a backward step and that these cuts should not be made and in a number of cases I think they justified a budget that was larger than the original budget that you had presented to us.

I asked them specific questions as to this 30-percent cut in teaching grants to the medical schools. And the testimony was, from deans of medical schools whom we had before us, that they are in a bad situation economically, and that this is going to do a tremendous amount of harm to their teaching programs. There was not one who appeared before this committee, who is in the business—such as the deans of these medical schools—who said that they could get along with this cut. I think Mr. Miles made the statement that from figures available to the Bureau of the Budget and the Public Health Service, the medical schools are in a better financial condition than they have been in past years. That is not the case from the testimony that we heard last week. According to that testimony, those are not good figures. I do not know where you got them. I hope you will read the testimony of some of these medical men who have the responsibility of running these medical schools, such as the University of Pennsylvania, and others throughout the country.

On the grants we had the same picture. I made it my business to ask them if they had at any time found any mismanagement of these funds under the grants and the answer was "No" every time. I asked them if they knew of any waste in these research-grant programs, and not one of them said there was. And these men have worked under these grants. I asked them if there were any of these programs that had not produced results and the answer was positively "No", that they have produced results. And that as a result of these grants, especially in research, the people are much better off than they were 3 or 4 or 5 years ago.

I am very disappointed in the action of the Bureau of the Budget on this budget. These two new institutes that were just set up by Congress, on arthritis and metabolic diseases, and neurology and blindness, are where the biggest cuts came and it was testified that that was where some of the greatest need exists at the present time.

I think we are making a great mistake. I think instead of cutting these grants that we should increase them. You have been with this program a short time, and I do not know exactly how, as Secretary, you feel. I think as you gain experience with some of these programs, deep down in your heart you must think that we ought to be appropriating more money than we are at the present time and that we would get results if we did and get them more quickly.

Now, that is more of a speech on my part than anything else, but I feel very deeply about it. I have been living with this program now for 7 years and the more I see of it, the more important I think it is to all the people of the country, that we continue, that we do not stop the progress that has been made or retard the progress that can be made in the next few years, just in order to make a cut of a few million dollars. It is a small item in the overall budget that we are faced with.

Mrs. Secretary, has the Public Health Service been given permission to start staffing the new clinical center?

Secretary HOBBY. They have been in the process of staffing it for some time, Mr. Fogarty. The actual date for the opening has not yet been set. I talked to Dr. Scheele before I was up here the last time and many of these people, I am sure he told you, have been recruited.

Mr. FOGARTY. I understood that under the original freeze order they were stopped from recruiting.

Secretary HOBBY. They are going ahead with it.

Mr. FOGARTY. Would you think it a fair question if I asked you, Mrs. Secretary, how you feel about some of these research programs in the Public Health Service? Do you think they could efficiently spend more money in these fields and get results more quickly if they had more money?

Secretary HOBBY. Mr. Fogarty, I do not think I know enough about the program to give you a detailed answer; but I am certain that in these areas you could always spend more money and the question that I think faces us now is that of not having the money and of being in debt. I never know what to do when you get in debt except to try to get out of it.

Mr. FOGARTY. But you know, Mrs. Secretary, in answer to that it was not many years ago in the Congress that some pretty conserva-

tive Members of Congress—I am thinking now of 1 or 2 who are now in the Senate—introduced bills in the House to appropriate $100 million for cancer research—$100 million. It was Mr. Keefe's thinking at that time that we could not efficiently spend $100 million, that we were not set up to do it. It was his opinion that we should go along as we have been going along in the past 7 or 8 years, and build up gradually and make sure that what we are appropriating will be well spent and will produce results.

But I think if the word went out that we are cutting appropriations for research for cancer and neurology and mental health and in these other fields, there would be a reaction on the part of the people, they would be demanding that Congress appropriate 2 or 3 times what we are expending at the present time. And if the demand were great enough, it would not make any difference what the national debt was. If the demand were there, we would appropriate the money.

As an example, I have opposed some of these big appropriations for the school construction and maintenance and operation programs in the past couple of years. We could not get a corporal's guard on the floor against those proposals. It would not make any difference if it were, as it was in the case of this last proposal, $20,500,000; or if it were $50,500,000, it would have passed by the same majority. There were only 18 votes against it in the House. So, when the demand is there I am afraid that if we cut back on some of these programs and the people get alarmed about it—and of course, these national organizations will; these medical men testified to that effect last week—if we start cutting back and the word gets out, and the demand comes, I think we will be appropriating more money than we can spend in an efficient way.

Personally, I cannot go along with these cuts, especially in Public Health and in some cases I feel that we may have to increase them over the original budget figures. I just wanted you to know how I stand on this.

That is all, Mr. Chairman.

REDUCTION RELATED TO CONTROLLABLE PROGRAMS

Mr. FERNANDEZ. Mr. Stephens, what did you say was the total over-all original budget?

Mr. STEPHENS. $1,786,528,761.

Mr. FERNANDEZ. What did you say was the total of what is designated as the uncontrollable items?

Mr. STEPHENS. $1,340 million.

Mr. FERNANDEZ. And what did you say was the total cut?

Mr. STEPHENS. $63,383,891.

Mr. FERNANDEZ. Could you figure for us the percentage of the cut based on the budget exclusive of the uncontrollable items?

Mr. STEPHENS. Yes, sir. I was going to mention that for Mr. Jensen's benefit. The cut, deducting the noncontrollable items, is 14.2 percent.

Mr. FERNANDEZ. On the total it would be 6 percent, did you say?

Mr. STEPHENS. 3.5 percent approximately.

PUBLIC HEALTH REDUCTION

Mr. FOGARTY. Please tell the committee what the Public Health Service cut was; it was about 19 percent.

Mr. STEPHENS. The total cut in the Public Health Service was 18.9 percent.

Mr. FERNANDEZ. It is 18.9 percent in Public Health?

Mr. STEPHENS. Yes, sir. I do not think that statement should stand just like that. There was $15 million in there for research construction.

Mr. FOGARTY. I told you the other day that the budget figure you had and the one we held hearings on, included the $15 million, so it was a 19-percent cut.

Mr. STEPHENS. Including that, yes, sir.

Mr. FOGARTY. We have not taken action on the $15 million. The Bureau of the Budget has, but the Congress has not.

Mr. BUSBEY. Are there any further questions? If not, the committee will stand adjourned until 2 o'clock.

PUBLIC HEALTH SERVICE REVISED BUDGET

WITNESSES

DR. LEONARD A. SCHEELE, SURGEON GENERAL
DR. W. H. SEBRELL, JR., DIRECTOR, NATIONAL INSTITUTES OF HEALTH
ROY L. HARLOW, CHIEF FINANCE OFFICER, PUBLIC HEALTH SERVICE
M. A. STEPHENS, BUDGET OFFICER, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. BUSBEY. Gentlemen, we have requested your presence here this afternoon in order that the committee might have the advantage of your analysis of the revised budget in regard to the Public Health Service and especially the National Institutes of Health which I believe were cut much more percentagewise than the rest of the Service. In view of that, Dr. Scheele, it might be best to present the analysis of the budget revisions for the Institutes first.

Dr. SCHEELE. I would be glad to speak to that, Mr. Chairman, if you wish; however, Dr. Sebrell has a prepared statement which deals specifically with the revisions in this part of the Service.

NATIONAL INSTITUTES OF HEALTH

Mr. BUSBEY. Dr. Sebrell, you did a good job of presenting the original budget to this committee and we will appreciate it if you will tell us of the changes that have since been made and how they will affect the National Institutes of Health.

Dr. SEBRELL. Thank you very much. I have some statements prepared here which we can distribute which might be helpful.

THE PRODUCTIVITY OF RESEARCH

Before discussing the National Institutes of Health budget, a brief outline of current progress in medical research—in effect, the return that the Nation receives on its investment in medical research—may be helpful.

In broad terms, it is clear that since the end of World War II, this country has launched the most extensive research offensive against disease that the world has ever known. In dealing with the major chronic diseases, which are the major objective of this attack, we must think in terms of a 30-year war and not in terms of a 5-year skirmish.

We are now beginning to reap the benefits of the first phases of this battle. More is known about cancer—how cancer cells differ from other cells, what will change normal to cancerous cells, how to detect cancer in early stages, how to use X-ray and surgery to cure a larger number of victims—than ever before. We know more about the heart diseases. New therapeutic drugs are either on the market or coming from the laboratory. Remarkable surgical techniques are being developed. Better drugs to retard blood clotting are available. Remarkable advances in understanding hardening of the arteries will be discussed below.

In the field of disorders of the nervous system, the extremely complicated process of conduction of nerve impulses is becoming clearer. Epileptic seizures can today be controlled and suppressed to a degree that would have been considered visionary a few years ago.

The ultimate cause of mental disorders remains obscure. But we are beginning to trace down what appear to be physical phenomena that accompany mental disorders.

If this tremendously stimulating and vigorous approach to all areas of medical research can be sustained and strengthened, we have before us the prospect of advance in medicine that will revolutionize the field of chronic diseases in the same manner that understanding of microorganisms revolutionized our understanding and control of infectious diseases.

Medical science—and all science—is tightly interrelated. Progress rests upon the imaginative, organized, patient work of a host of investigators. The bulk of new knowledge is accumulated in small bits which ultimately form a pattern. Without the small bits, the big pattern can never emerge. When a startling discovery is announced, it is rarely recognized that the major finding is simply the capstone of an arch built by other investigators over the years.

For this reason, it would be misleading and a disservice to medical research to rest the case for support on the relatively few climatic events that are often mistaken for the whole of medical research.

In supporting medical research, the Congress is for the most part supporting the indispensable, undramatic, continuing work that is the great body of medical research.

In concrete terms, the research grants distributed by the National Institutes of Health support about 25 percent of all medical research done in medical schools in this country, and this 25 percent is expended on virtually every kind of research and every kind of human disease.

Are these the key advances or not? We know that our advisers from medical schools and universities are selected from the best scientific minds in the country, and they do a good job of selecting men and ideas to support. The work which we support is therefore of very high caliber.

The predictable pattern of events under an expanded program of medical research is developing. The bits and pieces are coalescing into important general advances.

30853—53—pt. 2——47

Some of these advances that have been made possible by the appropriations under consideration may interest the committee. But before discussing them I wish to repeat that research is interrelated. Rarely is any major advance attributable solely to one man or group, for there are few human endeavors that involve the tight interdependence characteristic of research.

Recent progress in coping with various diseases and disorders of the heart and circulatory system is an area well suited to serve as a symbol of research advances in all medical fields. In some areas, the advances have not brought us as close to direct clinical application as in the heart field. In some others, the applications to clinical medicine are even more direct.

The discoveries outlined below are symbolic end products. They, in themselves, are only a part of the justification for support of medical research.

One of the most important diseases grouped under the general heading of heart disease is hardening of the arteries. Technically, the most common type of hardening of the arteries is atherosclerosis, a disease characterized by deposits of fatty substances in blood-vessel walls. When these deposits become excessive they impair blood flow in the arteries and tend to promote the formation of clots of blood with frank stoppage of blood flow in a vessel. When such an event occurs in the vessels of the heart muscle it produces a coronary attack with serious and frequently fatal outcome. Atherosclerosis of these and other vital vessels is either the sole or an important contributing cause of the death of about a quarter of a million people per year.

Until recently, practically nothing was known about the cause of the disease. Now we have good evidence on the nature of the material which results in the fatty substance being deposited in blood-vessel walls. This was determined by an investigator working with the aid of a Public Health Service research grant. We also have a pretty good idea why it is deposited in some individuals and not in others. People who appear to be developing atherosclerosis have excessive amounts of specific large abnormal fat-bearing molecules in their blood. The exact characteristics of these molecules are being tracked down. Scientists in National Institutes of Health laboratories have complemented these findings by discovering that a complex of proteins in the blood will clear up the milky appearance of blood occurring after fat has been eaten, and alter that portion of the fat which now seems to be implicated in producing fatty deposits in arterial walls.

If I might digress for just a moment, the current issue of the Journal of the American Medical Association, which came to my desk yesterday, has a three-page article on arteriosclerosis. This article, as most scientific articles are, was written with reference to research done on this subject, and we just took this article and checked the references in it. Fifteen of the references in this one article were to projects or laboratories that are being supported by National Institutes of Health grants. Furthermore, I quote this from the article as a matter of interest:

> Whether it leads some day to a clinical program or not, the work of Christian B. Anfinsen, Edwin Boyle, and Ray K. Brown (National Heart Institute, Bethesda, Md.) is a tour de force of the canniest reasoning and most assiduous analytical technique in decades.

In this same journal there happens to be another article by one of our staff members, contributed at the request of the council of foods and nutrition of the American Medical Association.

I cite that to give you an idea of the importance of this grant program in the medical field.

Neither preventive measures nor a cure for atherosclerosis are yet clearly in sight, but the disease is no longer the baffling mystery that it was a few years ago. Research leads are opening up that will, at a minimum, provide a sure and simple test for detecting the defects in the ability of the body to handle fat and consequently favors hardening of the arteries. This should be possible long before clinical symptoms develop. A full understanding of the disease and its ultimate origins leading ultimately to prevention or cure, is probably years away. But progress is firmly predictable, given stability of support for the large group of biochemists, biophysicists, and physicians who must work on the problem.

This set of achievements, each of which is the top of a pyramid of related contributory findings, is a prelude to what can be expected in the heart field over the next few years. There has been comparable progress, some clinically usable and other in more basic fields, in all areas. But in all areas, the key element is the rate of progress and not proximity to the goal.

Now, at this point I would like to take up the structure of the National Institutes of Health budget. But before doing so, I have prepared a summary of research accomplishments covering the fiscal year 1952 and offer it for the record, if you would like to have it, and also some recent accomplishments briefly summarized as examples which the members of the committee might like to have. It is too long to present here. We have boiled it down as much as we can to give you a picture of the activities.

THE STRUCTURE OF THE NATIONAL INSTITUTES OF HEALTH BUDGET

To explain the differences between the fiscal year 1954 printed executive budget and the President's revised budget for the National Institutes of Health the budgets, complicated in detail, will be discussed in terms of general functions—what can and cannot be accomplished by the two budgets under comparison.

The figures will be rounded off. Precise figures are, of course, available and can be brought into the discussion at any point desired.

As you know, the budget of the National Institutes of Health covers three broad sets of activities—support of medical research and research related functions, in non-Federal institutions through grants, support of chronic-disease-contol measures in States by grants and technical assistance to them, and operation of the National Institutes of Health laboratories, including the new clinical center.

These 3 broad functions are handled operationally by the 7 institutes that comprise the National Institutes of Health. They cover the general fields of arthritis and metabolic diseases, microbiology, neurology, cancer, mental health, heart, and dental diseases. In addition, there is an eighth operating unit which administers research and related grant programs that do not fall clearly within the province of any one Institute. The entire program is built around these groups of diseases, but the major effects of the two budgets on efforts to deal

with each of them can be pointed out in general items rather than in terms of the budget of each Institute separately.

This general picture can be viewed most effectively in terms of what the dollars provide—research teams at work in medical schools and universities, clinical and laboratory research in progress in the Clinical Center, aid in early diagnosis of heart disease and cancer, and so forth—rather than in terms of the dollars themselves. As with the military budget, the essential point is what defensive protection is being purchased—in this case, protection against disease; in the case of the Armed Forces, protection against armed aggression.

Financial support for the total current medical research effort of the Nation—industrial, university, and governmental—comes from various sources—industrial and pharmaceutical firms, the voluntary groups like the American Cancer Society, the American Heart Association, and the National Foundation for Infantile Paralysis, the endowment income of medical schools and universities and Federal expenditures. Changes of millions of dollars in Federal support represent sums which are of great significance for the country as a whole.

Since the difference between the two budgets is most marked in the grants area, this will be explained first.

GRANTS UNDER THE TWO BUDGETS

The printed budget for grants was drawn up on four major premises. Underlying the whole proposed budget was the first assumption that medical research is economically productive—that it expands the productivity of the labor force, the output of the economy, and the tax base to an extent that returns manyfold the dollar investment.

Second, the momentum generated by the joint private-governmental drive on the two great killers—cancer and heart disease—would be sustained. A drop in Federal aid would not in all probability be offset in the foreseeable future by a corresponding rise in State appropriations or private giving. Therefore, diminution of Federal aid to universities, medical schools, and other private research institutions would disrupt productive scientific effort in these fields.

Third, in the postwar public and private expansion of medical research support, investigations in five areas have been particularly handicapped by the paucity of funds. These are general medical research relating to the fundamentals of all disease, arthritis and metabolic diseases, microbiology, neurology, and mental health.

Fourth, the general condition of the medical research physical plants of the Nation, and of the Nation's medical research manpower pool make advisable the reactivation of the interrupted research facilities construction program and expansion of grants for teaching and training related to major chronic disease areas.

These assumptions as to research needs were not altered in the President's revised budget. One basic consideration unrelated to the desirability of carrying out the policies inherent in the 1954 printed executive budget led to downward revisions. This paramount consideration was economy in Federal expenditures.

With this background, the major differences between the two budgets in the research grant area can be presented.

RESEARCH SUPPORT

Grants to medical schools and universities for the proposed support of research projects were reduced by $7 million—$500,000 reduction in general medical research, $1.2 million in arthritis, $1 million in microbiology, about $340,000 in dental research, $2.8 million in neurological diseases (epilepsy, cerebral palsy, muscular dystrophy, and other diseases involving breakdown of the functioning of the nervous system), and $1 million in mental health.

In these areas support from all public and private sources has been on a relatively small scale in relation to the size of the disease problems and potential research achievements. When the figures are translated into the postponement of hope for victims of these diseases, the balance between economy and further research progress is particularly a difficult decision to make.

We have not yet as a Nation drawn the optimum number of highly trained people into medical research. We have not yet given medical scientists the optimum supplies, equipment, and supporting assistants that they need to work most effectively. The point of diminishing returns from Federal medical research support, particularly when the potential gains are considered, has not been approached.

RESEARCH RELATED TEACHING AND TRAINING

Support of teaching cancer and heart in medical schools is reduced by $1 million—$600,000 from cancer and $400,000 from heart. Funds to support the training of mental-health personnel are reduced by $1.2 million. Training stipends in the areas of arthritis, neurology, cancer and heart disease are reduced by a total of about $500,000. The total reduction in this area thus amounts to $2.7 million.

The proposed reduction of funds in these areas will reduce proportionately the quality and quantity of the highly trained manpower required to deal with all aspects of the affected diseases.

Three points are worth particular mention. First, our continuing contact with medical-school deans in the course of administering these programs gives us the firm conviction that teaching grants are of the utmost value to the Nation's medical schools. Second, the training program for mental-health personnel is, as contrasted with all other medical areas, the backbone of the total National training program in this field. Third, it should be noted that the revised budget is not only below the printed budget but also below the existing level of support in this area. Since the bulk of these grants go to pay teaching salaries in a number of institutions, some faculty members whose salaries are paid from teaching grant funds will have to be released.

RESEARCH CONSTRUCTION GRANTS PROGRAM

Reactivation of construction assistance to medical schools and other medical research centers was proposed in the printed budget.

With the general postwar increase in the Nation's medical research effort, many non-Federal institutions found that the critical factor limiting the scope and also the nature of their investigations was a severe shortage of laboratory space. The general financial condition

of medical research centers—and particularly of medical schools—was such that they could not undertake without aid the needed research-laboratory-construction program.

When it became evident that the required funds would not be forthcoming unless the Federal Government contributed, Congress appropriated funds for grants to cancer and heart research centers. The first appropriation was made in fiscal year 1948. The program was suspended in 1950, coincident with the Korean situation. During this period approximately $22 million was made available for construction of medical research laboratories and closely related facilities.

The results of the program over only the 3-year period exceeded the high hopes that were held. Construction of 89 facilities was aided. The construction was for the completion of new facilities, expansion of existing laboratories and renovation. In the great majority of cases, the Federal funds were added to those raised locally, and frequently the availability of Federal funds provided the needed stimulus to local fund-raising campaigns. Finally, the research construction inevitably improved teaching programs.

The printed budget proposed that this program be reactivated at a level of $15 million in fiscal year 1954 since construction needs have become even more urgent since 1950. It was also proposed that construction aid on a relatively small scale be extended beyond the cancer and heart fields to include construction of special research facilities for the study of arthritis and metabolic diseases, neurological disorders, mental disorders and dental diseases.

In the interest of economy, the President's revised budget includes no funds for construction of research facilities.

GRANTS TO STATES

The programs of grants to States cover the Service as a whole, and I would mention only that part that involves the National Institutes of Health. Surgeon General Scheele, I believe, would want to talk about the entire program.

In the part of this program financed by appropriations to the National Institutes of Health, the President's revised budget proposes that chronic disease control grants to States, including federally provided technical assistance, be reduced by approximately $2 million below the printed budget. Their purpose is to speed the application of research findings to mass control of major chronic diseases.

The degree to which the efforts of States to help in early diagnosis and case finding will be curtailed will, under the revised budget, depend on the ability and willingness of the State legislatures to increase appropriations in these fields, and there is also the mechanical problem of some of the legislatures only meeting every 2 years.

LABORATORY AND CLINICAL RESEARCH

Now, on our direct laboratory operations, the revised budget provides, as does the printed budget, for beginning in the clinical center an integrated program of laboratory and clinical investigations covering the major categories of disease which now affect the health of our Nation. Practically all new positions in the printed budget were aimed at adding clinical investigation to already existing laboratory

research in other institutes. Even with the initiation of laboratory research in the new Institute of Neurological Diseases and Blindness, and a small expansion of mental health, both budgets propose a net reduction of the total National Institutes of Health laboratory research program.

The difference between the two budgets centers around the rate at which clinical research and related activities would expand to use the newly constructed clinical center.

The revised budget reduces the total funds for direct research by $1.8 million below the printed budget. This reduction involves a $1.3 million reduction in the clinical research program and about $500,000 reduction in the laboratory program.

The dollars in the printed budget reflected a decision to admit patients to the clinical center in April 1953, to have 150 beds activated by July 1, 1953, to progress to 300 beds by July 1, 1954, and to build concurrently a clinical and related research program which would provide the most effective use of research manpower and the new facilities.

The revised budget reflects a change in the opening date to July 1953 the rate at which the clinical center will progress toward the 500-bed capacity, and the rate at which the research program built around the patients will develop.

In summary, the $1.3 million reduction proposed for clinical research in the revised budget will require a delay, both in activating beds and in establishing related clinical research programs, and the attainment of a level of 250 rather than 300 research beds by July 1, 1954. Since only actual operation can give us reliable cost experience, both the original and the revised estimates may be subject to error as a reliable index of clinical center needs.

Three major considerations bear upon the adjustments in program that may be required in the areas of clinical and laboratory investigation to operate within the revised budget.

During the first months of operation, clinical research teams will be busy designing experiments, working out experimental schedules and conducting relatively simple and inexpensive clinical experiments. For this reason, the total costs of providing bedside patient care may be somewhat lower for some months than we have estimated. In addition, the change in the opening date will mean that the research staff will be smaller during the early months than was anticipated in the printed budget. This would tend to reduce the possibility that the funds provided will not be adequate to meet the planned bed activation schedule while at the same time providing the best medical care. Later, of course, the clinical research will become more complex and extensive and hence more costly.

POSSIBILITY OF LOWERING THE RATE OF BED ACTIVATION AT CLINICAL CENTER

Despite the possibility of economies such as those mentioned above, we must be prepared for the contingency that it will not be possible to meet the planned bed activation schedule without reducing the quality of medical care to an unacceptable level within the funds provided.

If this situation were to arise, we would lower the rate of bed activation in order to assure that those admitted will receive the best medical care. At the same time, those who are admitted would be selected very carefully so as to have the least adverse effect on clinical research programs.

The revised budget proposes a reduction of $450,000 below the printed budget in funds assigned to laboratory research. A retrenchment to this extent is possible next year because there will be some shift of research talent from the laboratory to the clinic. Too, a period of some months will be required to determine the modification of our laboratory research which will be necessary to achieve the most effective combined laboratory-clinical investigations. It should be noted, however, when the research areas to be affected are identified, some expansion of laboratory research will be essential in subsequent fiscal years if we are to support a sound laboratory and clinical research operation in the areas of our designated responsibility.

The level of the visiting scientist program, which is at a token level in both budgets, should be expanded at a later date in order to make the clinical center truly a national research resource.

In concluding, I should like to point out that the two budgets have been compared only from the viewpoint of their relative effects upon medical research and related activities. Insofar as decisions on the budget involve other considerations, particularly general fiscal and economic questions, I am not competent to express an opinion. The revised budget proposes reductions below the printed budget that will necessitate a number of adjustments by us, by medical schools and other research institutions, and by States.

I believe that the revised budget before you represents minimum funds to sustain our medical-research program during the coming fiscal year. It will be a troublesome year and we can predict that it will be an exciting one. We know we have your best wishes that it will also be a profitable one.

OTHER PUBLIC HEALTH ACTIVITIES

Mr. BUSBEY. Dr. Scheele, would you like to comment on the situation as it affects other programs besides the National Institutes of Health?

VENEREAL DISEASE CONTROL

Dr. SCHEELE. Yes, Mr. Chairman; I would.

In the title "Venereal Disease Control," the reduction from the printed budget or below the level of the printed budget is $1,630,000. This would be distributed approximately as follows: A reduction of $1,500,000 in grants to States; a reduction in clinical laboratory research in the Public Health Service by roughly $5,000; a reduction of $113,000 in personal services, travel, and other objects in technical assistance to the States; in addition, there would be a $12,000 reduction in personal services, travel, and other objects in the administration of the venereal-disease-control program.

CONTROL OF TUBERCULOSIS

In the title "Control of Tuberculosis," the reduction here is $1,920,000 which would be distributed roughly as follows: A $1,300,000 reduction in grants to States for tuberculosis control; in cooperative applied research a reduction of $40,000; in technical assistance to the States, $531,000, which is in the area of mass-case findings, mass chest X-ray surveys, that I will refer to in a moment, and in administration $49,000.

ASSISTANCE TO STATES, GENERAL

Under the title "Assistance to States, General," the reduction is $100,000 distributed $98,000 in technical assistance to the States, $2,000 in vital statistics.

In the program of assistance to the States we refer to here and which Dr. Sebrell referred to, there is a 17 percent overall reduction in the grants to States. That is exclusive of those for hospital construction. The other major item is the liquidation of the TB mass X-ray surveys in large cities.

Mr. FERNANDEZ. Those are the reductions from the printed budget?

Dr. SCHEELE. That is right; those are the reductions from the printed budget.

REVISED ESTIMATES COMPARED WITH 195. APPROPRIATIONS

Mr. FERNANDEZ. How do the revised requests compare with the current appropriations?

Dr. SCHEELE. Would you like those by objects or would you like those by total amounts?

Mr. FERNANDEZ. I was interested only in the last one that you mentioned.

Dr. SCHEELE. In the general assistance to the States, compared with 1953, there is a $15,000 increase over 1953 in general assistance to the States. In tuberculosis it is $2,497,000 less.

Mr. FERNANDEZ. Less?

Dr. SCHEELE. Yes, sir. In venereal-disease control it is $2,995,175 less. The earlier printed budget was below the level of 1953.

Mr. FERNANDEZ. I see.

Dr. SCHEELE. In the title, "Engineering, Sanitation, and Industrial Hygiene," the net change is $135,000 which is distributed through travel, some reduction in personal services, in environmental research activities, in water supply and pollution control, radiological health services, and general sanitation activities.

In the case of water-pollution-control grants, the item of $900,000 was stricken. In other words, there is no proposal in the revised budget for grants to States and interstate agencies for industrial-waste studies, surveys, and research.

In disease and sanitation investigations and control, Territory of Alaska, there is a $25,000 reduction distributed between technical assistance to Alaska and field and laboratory investigations, divided roughly equally between those two.

In the title, "Control of Communicable Diseases," there is a reduction of $400,000 below the printed budget, distributed $131,700

in general disease prevention control activities and $248,300 in specific disease prevention control activities, and $20,000 in administration.

In grants for hospital construction, the reduction is $15 million, from $75 million in the printed budget to a request for $60 million.

In the liquidation of contract authorization grants for hospital construction, the reduction is $104,000.

Under "Salaries and expenses, hospital-construction services," the reduction is $75,000 distributed $69,440 in operations and technical-service activities and $5,560 in administration.

In hospitals and medical care, the reduction is $3,288,000.

If you wish additional details on that, Mr. Harlow will be prepared to give that in a few moments.

In foreign quarantine service, the reduction is $50,000 distributed $14,000 in medical examination of aliens and quarantine inspection of persons, vessels, and aircraft entering United States ports; $35,000 in medical examination of visa applicants in foreign countries; and $1,000 in administration.

There is a reduction of $18,000 in the amount for retired pay of commissioned officers.

In the item, "Salaries and expenses, Office of the Surgeon General," there is a reduction of $38,000 distributed $12,000 in public health methods and reports, $10,000 in international health activities, and $16,000 in management and central services.

Those, Mr. Chairman, represent the changes in the proposed budget for 1954 in contrast with the printed budget that was presented to you.

STATE PERSONNEL SUPPORTED BY FEDERAL FUNDS

Mr. BUSBEY. Under the item, "Assistance to States, General," do you pay a certain percentage of the salaries of nurses and other employees in the public health services of the States?

Dr. SCHEELE. Yes, sir; we do in some instances. It is variable with the States and with the particular programs. There is no restriction on the use of funds as between salaries or other types of services in operating the State health programs.

Mr. BUSBEY. To what State salaries do we contribute?

Dr. SCHEELE. I think we would have to check that for you, and get the number of State employees who are getting a part or all of their salary from grants.

Mr. BUSBEY. I was not thinking particularly about the number of employees, but the classification of their work, such as nurses, doctors, and so forth.

Dr. SCHEELE. Sanitary engineers, technicians in the field of diagnosis of venereal diseases and communicable diseases; that is, laboratory diagnosis; in some instances, the salaries of individuals running heart clinics or individuals running the tumor registry; technicians and pathologists who are examining slides on which there is material taken from the female cervix as a means of diagnosing cancer.

Mr. HARLOW. I think we might approach this from the angle that the probabilities are, this may be a crude figure, that for every $6,000 that we grant to the States there is a health worker involved; his salary and what it takes to keep him in the field, supply him pay for travel, and so forth. So that a $6 million cut in the State grants probably involves as many as 1,000 health workers. We would be

contributing to that many people as though they were on our own payroll, let us say.

Dr. SCHEELE. In other words, those people, unless the States find other sources of money, will be dropped by the States as a result of the proposed reductions in the grants to the States.

Mr. BUSBEY. How many nurses throughout the United States who are working for State public health services would be receiving a portion of their salary from grants in this budget?

Dr. SCHEELE. I do not have that figure, Mr. Chairman. We can try to get that.

Mr. BUSBEY. Could you enlighten us on that, Mr. Harlow?

Mr. HARLOW. It would be a considerable number, but I do not know. I do not have the figure here.

Mr. BUSBEY. Do the States, in turn, give you a breakdown of where this money goes so far as personnel is concerned?

Mr. HARLOW. Yes. Each State presents a budget which lists all of the salaries that are chargeable to that budget. It shows the source of the funds to support it and all of the other items of expense that go into it. From an analysis of those budgets, we could calculate the extent to which we are contributing directly to the salaries of personnel in those States.

Dr. SCHEELE. Their expenditure of funds is clearly indicated, because there is an audit, a fiscal audit of those State expenditures by auditors from the Department of Health, Education, and Welfare. So that every penny of the Federal grant is accounted for by the States.

Mr. BUSBEY. You do not have any analysis as to what portion of the budget would go to the salaries of State employees, do you?

Mr. HARLOW. I am not sure that we have. I suspect that we have that, Mr. Chairman, already available, but we just do not have it with us.

Mr. BUSBEY. Could you supply that for the record, if you have it, please?

Mr. HARLOW. Yes, sir.

(The matter referred to follows:)

Number of full-time public-health workers of different classifications reported by State and local health departments in 1952

Class of personnel	Total personnel (State and local)	Employed by State health departments[1]	Employed by local health departments[2]
All types	53,671	17,674	35,997
Physicians	2,148	662	1,486
Nurses	14,055	1,379	12,676
Dentists	380	132	248
Sanitation personnel:			
Engineers	1,168	750	418
Others	8,053	1,087	6,966
Laboratory personnel	3,099	1,784	1,315
Health educators	516	235	281
Nutritionists	240	137	103
Medical or psychiatric social workers	377	177	200
Clerical, administrative, and fiscal personnel	15,435	7,413	8,022
Maintenance, service, and custodial workers	3,894	2,125	1,769
Others	4,306	1,793	2,513

[1] Includes the 48 States and the Territories.

[2] District of Columbia personnel included here. Personnel serving in "actual service" State health districts and "supervisory" State health districts included also. (Adjustment made to eliminate duplication in State personnel serving on State health district staffs.)

NOTE.—State personnel as of Jan. 1, 1952. Local personnel as of Dec. 31, 1951.

WATER FLUORIDATION ACTIVITIES

Mr. BUSBEY. Do you have any teams going around promoting the fluoridation program?

Dr. SCHEELE. There were some teams. There are some individuals this year who are on loan to States working in their dental control program who, in addition to their work examining schoolchildren are interested in the topical application of fluoride to the teeth. Beyond that our contact with the States on fluoridation of public water supplies is a consultation service that the States receive on request from our dental consultants in the 10 regional offices. We do not have teams that are at work in the field, as such, promoting fluoridation of the public water supply. On the other hand, we do furnish a consultation service.

GRANTS TO MEDICAL SCHOOLS

Mr. FOGARTY. Doctor, is there any indication from the medical schools that they can assume a 30-percent cut in the teaching grants?

Dr. SCHEELE. No, sir. My estimate is that the cut in the grants will lead to a cut in activities which they will not pick up with funds from another source. In general, the medical schools' finances are precarious. You may have noticed the statement by President Eisenhower which was carried in the newspapers this morning, when he called on the American public to aid in contributing $10 million to a voluntary agency which is attempting to raise money for medical schools. And in that statement he indicated that the schools are in a precarious position financially.

MASS X-RAY PROGRAM

Mr. FOGARTY. Are the cuts in grants to States under tuberculosis to be applied to the casefinding and mass X-ray program?

Dr. SCHEELE. Yes, sir; there and in grants to the States a part of which is used by the States for casefinding, too.

Mr. FOGARTY. What will happen to that program under a cut such as is suggested?

Dr. SCHEELE. The funds remaining in the casefinding program by the Public Health Service will be used to complete the survey in Pittsburgh and Allegheny County and then no surveys will be undertaken. The communities with which we have been working and helping to prepare for surveys will not have those surveys. At least they will not have them with Public Health Service assistance.

Mr. FOGARTY. With Federal assistance.

Dr. SCHEELE. Yes, sir.

Mr. FOGARTY. What would be the result if they just say, "If the Federal Government does not give us any funds, we will not continue this program"?

Dr. SCHEELE. Well, probably the best way to answer your question would be to say that through this X-ray survey program we have now examined 8 million people and we have found 49,000 undiagnosed, unknown cases of tuberculosis. With the cessation of the program, I do not believe the communities will be able to pick up this program, because this was started as a Federal program, because the equipment

is expensive. It is used in the course of a survey and then it is not used again in the same community. This just means that several thousand cases of tuberculosis are going to go undiagnosed, undiscovered each year in the future, with a cessation of the program.

Mr. FOGARTY. If this cut is allowed to stand in tuberculosis, would we be able to find out next year how many States or communities have abandoned this mass screening technique?

Dr. SCHEELE. Yes, sir; we should be able to find that. There will be some abandonment of tuberculosis case finding carried on under the grants in aid to the States, as well as the direct program that we do in the bigger cities.

STATES REPORTS ON EFFECT OF REDUCTIONS

In an effort to see what effect these cuts would have, we asked several States what would be the effect on their programs of the proposed reductions in the various grant items and you may be interested in knowing, for example, that California reported that the following changes in service would result.

1. Reduction of $100,000 aid to local health units serving 96 percent of State population, including $19,000 to Los Angeles County, $21,000 to Los Angeles City, and $9,000 to San Francisco.
2. Cripple VD case finding in military areas.
3. Curtail or abandon the tumor registry which now aids 39 hospitals to maintain observation of cancer patients.
4. Abandon project for early detection of heart disease which has had 4 years of existence and which now is making a major contribution.
5. Curtail or abandon training of technicians in cytology.
6. Abandon several local mental health programs.
7. Discontinue one-half of State mental health consultation and training activities.

In Mississippi they report the following changes in the program will be required with this reduction in funds:

There would be a reduction of 300 in number of new cases of cancer to be diagnosed and treated.

There would be a reduction of 250 in the number of cases of tuberculosis to be diagnosed and treated.

I might cite several figures here in connection with tuberculosis. They would be receiving $35,400 less money for tuberculosis control under the proposed reduction in the State grant item here. It costs a State or community roughly $30,000 to care for a case of tuberculosis. So, with a $35,400 reduction, Mississippi estimates 250 new cases of tuberculosis would not be diagnosed.

There would be a reduction of 2,400 cases of syphilis that would be discovered in the State.

There would be a reduction in nurses, doctors, and laboratory technicians in State and local health units on VD and tuberculosis control.

There would be the elimination of three Public Health nurses working in heart-disease control.

There would be the elimination of a social worker, psychologist, and two clinics in the mental health program.

In Ohio it was reported that the following changes in the program would be required with the reductions proposed.

In cancer, it would eliminate 6 nurses and 3 clerks; eliminate field records consultant and clerk: eliminate training of 2 nurses and 5 doctors in cancer; eliminate distribution of the cancer bulletin to physicians; postpone the installation of the tumor registry.

In the case of heart disease, it would eliminate 1 heart clinic in Lorraine; reduce the staff by 4 nurses and 2 clerks; reduce consultation to industry in early diagnosis of heart disease.

In tuberculosis, it would eliminate 2 of the 3 mobile X-ray units; eliminate 4 X-ray technicians, 2 clerks, 1 medical clinic director, 2 physicians who read films; there would be no replacement parts for X-rays in local health departments; would reduce 12 nurses and 2 clerks in local health units; and eliminate the rehabilitation program director.

In VD, it would eliminate the distribution of penicillin to physicians and clinics; it would eliminate all—that is, 5—VD investigators in district offices; eliminate a consultant nurse; eliminate 2 serologists, 2 laboratory technicians, and 2 laboratory assistants in the VD program. It will force the elimination of blood testing for industry, evaluation of local labs, and important research; eliminate the purchase and distribution of VD literature.

In mental health, it would eliminate 2 of the 19 mental health clinics; eliminate all training and lay education activities.

That is, if funds are not found from other sources.

POSSIBILITY OF ADDITIONAL STATE FINANCIAL SUPPORT

Mr. BUSBEY. Dr. Scheele, does not that assume that if these Federal grants are not forthcoming the States will take the attitude that they will not make any attempt to raise funds with which to make up this lack of Federal money?

Dr. SCHEELE. I would hope, Mr. Chairman, that they would make a serious effort to find money to make it up. On the other hand, 20 legislatures were scheduled to or did close their sessions by the end of March. Most State legislatures are now well along or finished with their activities for the year. Forty-one of the forty-eight legislatures in session this year operate on a biennial basis and therefore there would be probably a year's gap, or 2 years, before they could be successful even if their legislatures wanted to make up the difference, before they could get it.

Mr. BUSBEY. We hear that same argument put forth with reference to any and all of these grant and subsidy programs. It gets back to the old question about which came first, the hen or the egg. I would say that if the States were not any more interested than that in finding a way to finance these programs they cannot think too much of them. If they did, they would get the money.

Mr. FOGARTY. I cannot agree with your reasoning on that at all. If it had not been for the Federal Government, we would not have this program today. There would be thousands of people 6 feet under ground if the Federal Government had not spent some of this money.

I am convinced, just as surely as I am sitting here, that if we curtail these funds, we are going to hurt people. We are not going

to hurt segments of our economy, we are going to hurt people. And all of these people pay some form of taxes.

Then, too, I think that the burden on the States in caring for these people who have these diseases is too great. They cannot take care even of the mentally ill in the States. I do not believe there is a mental hospital that is staffed as it should be in any State in this country, because of a lack of funds on the State level.

I think that the burden of the care of these people is such a burden on the economy of the States that they cannot take over these other programs. I think that with help from the Federal Government from year to year they can make gains in the diagnosis and treatment of these diseases that will help relieve the burden on their local budgets so that in the future they may be able to take over more of the financing of all these programs.

But the thing that bothers me is, as I have said on a couple of occasions before, that we have just signed an International Wheat Agreement, covering the next 5 years. In the past 5 years that has cost us hundreds of millions of dollars, and we do not hear a word about it from anybody.

I do not know what these support programs are going to cost us. But those are programs designed to protect a certain segment of industry or a certain segment of our population, certain economic groups. It is for their protection, it is to keep them in business, it is to make money for them.

This is a program to try to keep people alive and healthy and to prevent or alleviate suffering that exists now amongst sick people.

When we tamper with a program like that, that will take something away from people who are sick and in need, I should think that we should have, or at least the Bureau of the Budget should have, given the States some notice or made some attempt to find out on a State-by-State basis what would happen if you cut $100,000 here or $100,000 there. In that way they would have been honest with us and with the people. In this way they are not. They just say, "Well, we will just see what will happen." That is all that they are saying. The end result is going to be that it will hurt these people who are so unfortunate as to be sick.

That is what bothers me in this whole program. It was testified here last week that the Bureau of the Budget cut the land-grant college appropriation 50 percent, but within 4 or 5 days the Bureau of the Budget rescinded that cut. They must have had a pretty good reason for doing it. That was done on the basis, so they claim, that the State legislatures had met already and most of them had adjourned and would not reconvene until 1955.

If that is true as to that program, it is certainly true in this program. I would not be a party to taking these things away from the people, and just taking the chance that the States will do something, when they cannot even take care of the sick that they have at the present time.

There is not a State in the Union that is doing everything it should in caring for those who are afflicted. Some people say that the incidence of TB is going down, that the death rate from TB has gone down. What is it now, seventh or eighth in the causes of death?

Dr. SCHEELE. Yes.

Mr. FOGARTY. It used to be much higher. They say, therefore, that we have got it under control. But we do not have it under

control. They say the same thing about VD, but VD is still prevalent even though we have penicillin and other antibiotics that will cure it. It is still a medical and social problem; is it not?

Dr. SCHEELE. Yes, sir; it is.

Mr. FOGARTY. Especially in a time of emergency like this.

Dr. SCHEELE. Mr. Chairman, in fairness to the States I think we should point out that the States have been making a very sincere effort to increase their own contribution to the public health programs. I have a few figures here. California, for instance: Federal funds were 21.6 percent of their total public health budget in the fiscal year 1947. In the fiscal year 1951 Federal funds were only 10.8 percent. In other words, the State was making a real response to increasing its own support.

Take the figures for Kentucky. In the fiscal year 1947 the figure was 48.5 percent of their total health budget. That dropped to 25.9 percent in 1951.

Mr. BUSBEY. Are you reading from a tabulation of all the States, Dr. Scheele?

Dr. SCHEELE. Yes, sir.

Mr. BUSBEY. I wonder if we should not insert that in the record at this point.

Dr. SCHEELE. I should be happy to.

Mr. BUSBEY. Without objection, it will be inserted in the record at this point.

(The matter referred to is as follows:)

Percentage which Federal funds [1] constitute of total health expenditures as reported by State agencies participating in grant programs

State	Fiscal year 1951	Fiscal year 1949	Fiscal year 1947	Trend	State	Fiscal year 1951	Fiscal year 1949	Fiscal year 1947	Trend
Total	21.7	25.8	31.2		Nevada	52.8	56.2	61.8	Down.
					New Hampshire	35.1	38.6	46.2	Down.
Alabama	43.7	42.0	47.7		New Jersey	43.8	34.4	37.6	
Arizona	45.9	48.0	51.1	Down.	New Mexico	37.7	48.3	57.4	Down.
Arkansas	47.5	55.2	53.6		New York	8.0	9.2	13.5	Down.
California	10.8	11.3	21.6	Down.	North Carolina	33.8	38.2	36.0	
Colorado	29.9	32.1	59.8	Down.	North Dakota	39.4	47.8	51.6	Down.
Connecticut	21.4	23.5	23.5	Down.	Ohio	22.1	29.2	22.1	
Delaware	42.1	39.9	46.1		Oklahoma	35.9	41.0	44.4	Down.
District of Columbia	18.4	22.8	25.2	Down.	Oregon	20.7	23.0	33.3	Down.
Florida	24.2	27.9	42.2	Down.	Pennsylvania	18.8	23.4	25.7	Down.
Georgia	34.2	34.1	37.8		Rhode Island	38.6	40.7	44.6	Down.
Idaho	46.1	52.1	62.5	Down.	South Carolina	49.9	47.2	59.1	
Illinois	10.9	16.4	27.7	Down.	South Dakota	54.1	59.9	66.6	Down.
Indiana	25.9	30.3	50.7	Down.	Tennessee	36.3	39.4	46.7	Down.
Iowa	43.6	42.1	45.3		Texas	38.0	36.3	47.0	
Kansas	28.9	33.2	41.7	Down.	Utah	35.4	38.3	51.4	Down.
Kentucky	25.9	42.1	48.5	Down.	Vermont	38.3	49.4	57.0	Down.
Louisiana	34.6	38.0	40.1	Down.	Virginia	22.0	26.3	32.9	Down.
Maine	43.0	44.3	42.8		Washington	17.6	19.9	24.2	Down.
Maryland	15.7	18.8	24.0	Down.	West Virginia	40.5	55.2	53.9	
Massachusetts	21.6	23.2	25.9	Down.	Wisconsin	15.5	20.8	21.1	Down.
Michigan	20.6	17.9	19.5		Wyoming	59.2	61.4	52.1	
Minnesota	24.7	27.7	33.3	Down.	Alaska	78.9	85.3	63.8	
Mississippi	47.1	48.8	54.3	Down.	Hawaii	21.5	22.7	20.3	
Missouri	32.7	31.8	29.4	Up.	Puerto Rico	22.9	22.5	21.4	Up.
Montana	37.5	42.5	41.9		Virgin Islands	66.4	51.0	23.7	Up.
Nebraska	34.6	38.4	52.1	Down.					

[1] Federal funds include grants-in-aid for general health, tuberculosis, venereal disease, heart disease, cancer, mental health, industrial waste studies, hospital survey and planning, and Alaska grant which are administered by the Public Health Service. Federal funds also include maternal and child health and crippled children's grants administered by the Children's Bureau.

Source: Report of Expenditures for Health Services—Joint Financial Report, form 11.1 submitted annually by State health agencies to the Public Health Service.

Dr. SCHEELE. I should also like to make it clear to the committee that I am defending the reduced appropriation for the States, not the printed budget that was submitted earlier.

Mr. BUSBEY. I am sure the committee not only understands but appreciates your position.

Mr. FOGARTY. You are placed in that position, not because of your own feelings in the matter, but because of the laws and regulations governing the submittal of budgets to the Congress. These figures are not the figures of the agency or the Department or of you individually. These are the figures that you have been given by the Bureau of the Budget. The Department went to the Bureau of the Budget on at least two occasions, did they not?

Mr. STEPHENS. Yes, sir.

Mr. FOGARTY. The first time they sent you back and said "Cut some more," and you came back the second time and they cut further than you wanted a second time.

Mr. STEPHENS. The third time we got together.

Mr. FOGARTY. You gave in and they gave in, but there were still some further cuts above what you people had recommended.

CLINICAL CENTER

Now, what about your clinical center, Dr. Sebrell? That situation does not look good to me. It seemed to me the information we had from the Bureau of the Budget was that the clinical center program was not hurt at all, that they were just cutting the number of beds to be activated from 300 to 250. But this cut goes much further than that, does it not?

Dr. SEBRELL. It is the rate of activation with which we are concerned. If you reach 250 beds on the 30th of June, 1954, that is the total, but the rate at which you build up the personnel and the research to that figure on June 30 is an important consideration, and that has to be shifted according to the number of dollars available. So when you cut the dollars, you change the rate. We are going to try to do it just as economically as we can and still provide what has to be provided in this very unusual situation in which we will be. I cannot estimate accurately what the costs are going to be, because there are factors that I mentioned in my statement, but we will have to get some figures and come up here and tell you what the cost will be and explain it. This is a slower rate of activation.

Mr. FOGARTY. When was this temporary restriction on staffing the center lifted?

Dr. SEBRELL. The final lifting was April 16, I believe.

Dr. SCHEELE. That is approximately correct.

Dr. SEBRELL. I believe that is the date.

Mr. FOGARTY. Last week some time?

Dr. SEBRELL. Yes.

Mr. FOGARTY. So you have had a delay of 2 months?

Dr. SCHEELE. Yes.

Mr. FOGARTY. When was this so-called freeze order issued, the last of February?

Dr. SCHEELE. Early in February, I believe.

Mr. FOGARTY. So it is about 2 months.

Mr. STEPHENS. I have a whole file on that chronologically.

Mr. FOGARTY. When was the first order issued, what was the date?

Mr. STEPHENS. The first order was the Dodge letter, which told everybody to get in the groove and start reducing and it set out some policy. That letter was February 3, the original letter, when policy was announced.

Dr. SEBRELL. The clearance on the staffing came on April 16. We are taking people on now just as fast as we can and we will be taking patients the first week in July.

Mr. FOGARTY. You will?

Dr. SEBRELL. Unless some unusual thing happens.

Mr. STEPHENS. The original letter when policy was announced was February 3. On March 2 the agency wrote to Mr. Dodge and talked about this investment and that we had contemplated opening on April 1. There were two factors in the original Dodge letter. One was not to exceed the January rate of obligation and the other was concerning the hiring of new people. Our interpretation of the original Dodge letter was that if properly justified the Secretary or the Administrator would waive those two features.

Mr. FOGARTY. That was my understanding.

Mr. STEPHENS. The Administrator waived those two factors and told the Public Health Service so and merely reported it to the budget, that that was our interpretation of what they wanted. They came back and suggested that "We do not want to do that until we get some idea about how much money could be spared for 1954 so that the action for the remainder of this year would tie in to what will progress next year."

Dr. SCHEELE. Mr. Chairman, with your permission, we would like to extend our remarks a bit on how we tentatively propose to take the reductions in our hospital program. We very much need the advice of the committee, because we face a difficult problem, that if we are to take these cuts, we need to begin giving notice on hospital closures within a matter of a week or two. Otherwise we will come up to July 1 and have to absorb even more during the next year and the blow will be all the harder. With your permission I would like to ask Mr. Harlow to tell you our tentative proposal for the absorption of that cut.

Mr. FERNANDEZ. I was going to ask about that particular situation when Mr. Fogarty finished his questioning.

Mr. FOGARTY. I have finished, Mr. Chairman.

Mr. FERNANDEZ. Dr. Scheele, I do not think it is necessary for you, as Surgeon General, to be placed in a position of defending these reductions, as was stated here a minute ago. I think that your true position before this committee at the present time is that of defending the reduced figures from further reduction by this committee. I think you have a job right there without having to defend the reductions already made.

Mr. BUSBEY. Does the gentleman have any knowledge that the committee has taken any action yet?

Mr. FERNANDEZ. I have heard considerable remarks by the chairman of the committee, who controls the committee to a large extent, as to the necessity of reducing and reducing more. I am drawing my own conclusions.

Mr. BUSBEY. That goes with all budgets, as far as I am concerned.

Mr. FERNANDEZ. Well, we have on the floor already one of the appropriation bills and if we are going to judge the temper of this Congress by what is happening to that appropriation bill, which was cut way below the revised budget, then I think there is need to be concerned as to what this committee and the Congress will do with these particular appropriations. So I repeat that I think the proper position of the Surgeon General is to defend the reduced figures from further reduction by the committee and by the Congress, and in so doing I think it is perfectly proper for the Surgeon General to tell us what effect these reductions already made are going to have on the program—on the total program, and on the specific items.

Mr. BUSBEY. That was the object of having the hearing this afternoon.

Mr. FERNANDEZ. I am not saying that he is precluded from doing that. I am merely pointing out that he is perfectly justified in speaking out strongly here, even though he is under an injunction to defend the reduction. I think what he should do here is defend the reduced figures from further reduction.

HOSPITAL CONSTRUCTION PROGRAM

Now, Doctor, what will be the effect of the reductions already recommended by the Bureau of the Budget with respect to hospital construction programs already undertaken, particularly with reference to split projects?

Mr. HARLOW. Mr. Chairman, there are about 30 States that have so-called split projects involved in this item in which they have projected into the next fiscal year a part of the cost of projects which are being undertaken in the current or previous fiscal year.

Now, in those States the reduction of $15 million in grant items will mean that 7 States will come out with less Federal money than the Federal share of their split projects. Those are Arkansas, Georgia, Kentucky, New Jersey, Ohio, Rhode Island, and South Carolina. The amounts or differences vary, of course, from State to State. Arkansas will be short $323,460; Georgia, $40,480; Kentucky, $210,569; New Jersey, $352,953; Ohio, $180,149; Rhode Island, $72,147; South Carolina, $341,724.

Now, we, of course, are unable at this time to say how many of the States, or the project sponsors—and that is really what we mean when we refer to the States in this program—will be able to find other sources of funds. Certainly, I would assume, as to some of the items where there is only a small difference, they might be able to do it. In others, I think I am safe in saying it is practically certain they will not be able to do so. This means that they either stretch out the project or slow up the construction in many of these projects. I think the natural conclusion there would be the total cost would probably be greater. Of course, the effect on the program throughout the country can be summarized by saying that we have an average cost of $16,000 per bed, and that $15 million, together with what the sponsors would put into it, will come close to erecting facilities with a total capacity of about 2,000 beds, or a little less.

Mr. FERNANDEZ. With respect to Arkansas, can you tell us briefly about what would happen to their particular projects if the proposed reduction in appropriations is made?

Mr. HARLOW. In Arkansas they have three projects which are split in 1954, the University of Arkansas Medical Center at Little Rock, $599,000—and this is the Federal share—the St. Vinson's Infirmary at Little Rock, $997,136, and the Fort Smith-St. Edwards Mercy Hospital, $50,000. Those total $1,646,136.

The 1954 allotment to the State will be $1,322,176, leaving a net deficiency of $323,460. There is only one project there where they could, by a shift perhaps, get it completed, and that would be the smaller item of $50,000 for the hospital at Fort Smith. In addition to that, I think there are some projects—certainly at least one in Arkansas, and I cannot call it to mind at the moment—where, because the entire amount available to the State has been split into three projects, they are unable at the present time to even authorize this other project in the State. I can supply for the record the projects involved there and the total estimated cost, but I do not have it with me. That would be true in a lot of the States.

For example, take South Carolina: They are putting all their money into the Charleston Medical College hospital facility, which means that there can be no new project started in the State in 1954.

Mr. FERNANDEZ. All the States will be affected as far as their hospital construction program is concerned; is that correct?

Mr. HARLOW. Every State.

ADVICE TO STATES REGARDING REVISED BUDGET

Mr. FERNANDEZ. In fairness to the States which will be affected, what steps are being taken by the Public Health Service to advise the States about the reductions that have already been recommended and probably will be approved, and what they may do to protect themselves in their planning for the future?

Mr. HARLOW. Mr. Chairman, it is our custom as a matter of information that as soon as any budget figures become public to advise the States if they are affected and tell them the extent they will be affected. We have only had the releases on these figures within the last few days; so, we are in the process of notifying the States on all these items, including hospital construction, what they can expect to receive if the budget figures are finally enacted into appropriations.

It is not our province, I take it, to tell them they should begin lobbying in Congress to see that they do not get these cuts. We merely inform them as to what the situation will be in terms of money if the budget figures become appropriations.

Mr. FERNANDEZ. I do not know that that could be interpreted as an attempt to have them get after their representatives in Congress about the matter, although certainly they should. But it may be that some of them will want to make plans to call back their legislatures to do something about this because the burden is going to be thrown back on them if these cuts are made. That will be true not only on this item but on many of these programs.

Mr. FOGARTY. What you said about the State legislatures being called back is true, but the hospital-construction program is a community program, like a couple of those projects in Arkansas which are sponsored by religious groups. They are the ones affected. So, it would not even be the State in those instances. It is religious groups and the local communities that put up the money.

Mr. FERNANDEZ. I take it that the local communities and the religious groups, since they appeal to the Federal Government for funds that when they cannot get them from the Federal Government the next place to which they can appeal is the State.

Mr. FOGARTY. They cannot get them from the State.

HOSPITALS AND MEDICAL-CARE PROGRAM

Mr. FERNANDEZ. I grant you that it would be pretty difficult in view of the situation in my State.

Not only this item but other items, including "Hospitals and medical care," will vitally affect my State. I will not ask you what you are going to do, but I assume you will advise the people who will be affected of plans already made or being made.

Mr. HARLOW. Yes.

May I take up the "Hospitals and medical care" item, briefly?

Mr. BUSBEY. We will be very happy to hear you, Mr. Harlow.

Mr. HARLOW. As the Surgeon General indicated, we feel that we need some advice from the committee since the Secretary is going to have to make some decisions or, shall we say approve or disapprove some things we might recommend in connection with this very substantial reduction in this item.

Dr. Scheele mentioned the total reduction in funds involved in this item, which amounts to $3,288,000 below the budget, of which $1,673,000 is in appropriated funds and $1,615,000 in reimbursable funds.

Now, there are certain things that obviously have to be done in the face of this type of reduction. In the first place, we would propose to eliminate all the program increases proposed in the original budget. You may recall we had some slight increases there for a followup on narcotic addiction, a pilot program on medical rehabilitation, in one or more of our hospitals, and so forth. Those would be eliminated. Then we would take administrative action to effect a total reduction in travel, which we think can be done to the extent of about 10 percent. We would also, of course, reduce our headquarters staffing, and we would also make some reductions in outpatient-clinic staffing and expenditures for food, supplies, and equipment.

Now, another thing that we would do, of course, because we are losing the veteran patients in our general hospitals and they always pay us for every patient of theirs we have, would be to calculate what the effect of that reduction would be upon the existing hospital system, hospital by hospital.

Now, if you will accept our calculations on this basis, after we have done all those things, we calculate that we will still have to reduce staff to the extent of some 270 additional positions in order to absorb what will remain of the cut. That leaves us with the inevitable conclusion that we will have to close hospitals, and in place of some of these hospitals substitute out-patient clinics.

Now, the first hospital on the list for closure from the standpoint of what would be left in the hospital after we take out the veterans will be the Cleveland Hospital.

We are operating this year with an average patient load of 139. We will lose 54 veterans, leaving a net load there of about 85. That is an operation which will be hard to justify on a continuing basis for

that type of a load. It has a constructed capacity of 189 beds. It is not a new structure but it is in good condition, and we always have had a satisfactory operation there. But with the elimination of the veteran patients, assuming the beneficiary load would not change, the hospital would be operating in 1954 at 45 percent of its constructed capacity.

Because of the size and arrangement of the Cleveland hospital, it would be extemely difficult to work out an efficient method of operating the hospital with such a low rate of utilization. Therefore, our first consideration there would be the closure of the Cleveland hospital.

Another factor for consideration there is the fact that we have hospitals in Chicago and in Detroit, which could pick up at least a part of that load that is now in the Cleveland hospital, and we could arrange through contracts with some of the local hospitals to take care of emergency cases which we would pick up in Cleveland. But that still would not give us a sufficient saving.

The next hospital in point of loss of patients which we would consider closing would be Savannah. The Savannah hospital has a constructed bed capacity of 117 and is operating with an average daily load of 123. We have 49 veterans there, or about 40 percent.

The situation in Savannah is unlike the situation in Cleveland because the way the building is constructed and operated, we could still get an efficient operation at its reduced level. Furthermore, it is the only Public Health Service hospital between New Orleans and Norfolk, and, frankly, we would not like to close the Savannah hospital strictly on the basis of its reduction in patient load due to the loss of veterans.

That brings us to another consideration, and that is the Fort Stanton Hospital in New Mexico, which is operated as a tubercular sanatorium. The hospital is, frankly, not necessary, we think, to the efficient operation of the Public Health Service hospital system. We can take care of the tubercular load that we have throughout the entire system in our hospitals at San Francisco, New Orleans, Detroit, and Manhattan Beach.

On the other hand, we fully realize that the hospital is a major economic factor in the life of the surrounding community, and we feel that there undoubtedly will be, as there has been in the past when it was rumored the hospital might close, considerable reaction and opposition to the closure of that hospital.

Now, Mr. Chairman, I would like to say this off the record.

(Discussion off the record.)

I would say that our recommendation, based strictly on the efficient operation of the hospital system of the Public Health Service, would be to close the hospital at Cleveland and close the hospital at Fort Stanton.

On the other hand, if we were to approach it strictly on the basis of the reduction in the patient load because of a loss of veterans, it would naturally follow we would close Cleveland and Savannah.

Now, if it is ever in order to ask the committee to give us some advice, we would like to pose that question for you now.

On the other hand, if you prefer that we work this out within our own organization and with the Secretary, we can handle it that way also.

Mr. BUSBEY. I would say that it would be a rather unusual request of the committee.

Mr. FOGARTY. It would be quite unusual; of course one of the members of the committee is affected, or his State is affected.

Mr. FERNANDEZ. My State will not like it, of course, but if it becomes a necessity, it will have to take it. These hospitals are not operated for the benefit of any State, but as I understand it, if Fort Stanton is closed, then those patients would have to be moved to San Francisco, Manhattan Beach, Detroit, or New Orleans.

Mr. HARLOW. Yes.

Mr. FERNANDEZ. All of which are in low, damp climates, whereas Fort Stanton is in a high altitude, in a dry climate, and in a State which is well known for its beneficial climate in cases of tuberculosis. Of course, that is one of the reasons Fort Stanton was turned into a tubercular hospital in the first place.

I think the proper thing to do is to give the Department the necessary funds to operate these hospitals. I do not think that we should try to balance the budget on the medical and hospital services of the country, and at the detriment, I might add, of the patients that the Federal Government is responsible for.

Mr. FOGARTY. I can also see your problem from your side of the table; that if a cut like this stands and if you do not take some action now, that by July 1 the cut would be that much greater, and it would be that much more harmful. At the same time, how can we, as a committee of one body of our legislature, tell you that this cut is going to stand. We have no control over what the Senate is going to do.

Mr. BUSBEY. We have no control over what the House is going to do, either. These appropriations are reported to the full committee and then from the full committee to the floor of the House. As you know, sometimes it is raised and sometimes it is cut further than the committee recommends, so while we are in sympathy with the problem that you are confronted with, I am just trying to think what we of the committee can do to help you.

Mr. FERNANDEZ. I agree with my colleague in that I do not see how our committee could undertake to tell the Service what to do. It seems to me that the Service should be left free to do that which is best for the Service under the appropriations they receive. I certainly would not stand by and let my State be discriminated against, but on the other hand I would not interfere with any action that the United States Public Health Service takes which is for the benefit of the medical-services program as a whole.

Mr. STEPHENS. That was an unusual request that Mr. Harlow made, but I am delighted that he made it because it lets you a little into our hearts, and it shows you that decisions like that require a lot of analysis. We try to do a soul-searching job and try to do it right. When the mobile hospital closed, I will bet you that I had 50 calls from people and Congressmen. None of them were disagreeable when they got the whole story, but it is a soul-searching job, and when Mr. Harlow drew it out he certainly let you gentlemen see that we try to analyze it. All angles are weighed.

Mr. FERNANDEZ. No one appreciates that more than I do.

Mr. HARLOW. Mr. Fogarty hit upon a thing that I did not mention, but which is a very grave situation with us, and that is, for example, the Fort Stanton operation on an annual basis costs us about $615,000. If we do not start closure until we know how much is to be appro-

priated, which will probably be some time in July, we can only save about $529,000 out of the 1954 funds, whereas if we start now we will get the closing expenses out of the 1953 appropriation.

Dr. SCHEELE. Our alternative is probably to dip into 1 more hospital, or 2 more hospitals for closure, if we wait until July 1, or soon thereafter, to begin our action.

Mr. HARLOW. It is probable if we do not get the word and this item stands—if we do not get the word until July 1—we will have to close three hospitals and they would be Fort Stanton, Cleveland, and Savannah. If we start now we can get by with closing two. If we wait until the first of the year we are going to have to close three.

Mr. BUSBEY. Is there any contemplation on the part of the Public Health Service of closing Cleveland anyway?

Mr. HARLOW. I would say we will probably be forced to close Cleveland under this reduced load because it would not be a good operation in that building.

Dr. SCHEELE. A part of this reduction is not handled by this committee; a part of this reduction will be handled by the subcommittee handling the Veterans' Administration appropriation.

Mr. BUSBEY. Mr. Harlow, we all appreciate your putting this frank statement of the situation in the record and advising us of the problem that you are up against. I do not see anything that the committee would have authority to do at the present time that would be of any real assistance to you.

Mr. FERNANDEZ. I join with the chairman in expressing appreciation of your speaking out frankly.

Mention was made awhile ago as to how much of the record should be printed. I think it should all be printed. I think this matter should be put out on the table.

Mr. BUSBEY. I do not know why it should not be in the record.

FINANCIAL CONDITION OF MEDICAL SCHOOLS

Dr. Scheele, do you know of any statistics that would substantiate the statements that have been made as to the financial condition of the medical schools as of today in comparison with a few years ago? Are there any comparative statistics as to the financial condition of the medical schools kept from year to year anywhere?

Dr. SCHEELE. I am not sure that there are. A few schools have cost accounting which breaks out the medical schools as a separate entity, but I am afraid in many instances parts of their overhead and so forth are integrated in the overall university budget and they do not stand out.

Mr. BUSBEY. It would not help unless we had the figures for all or a substantial majority of the medical schools so that we could see the picture as a whole and see which schools are in desperate financial condition and which schools are in, shall we say, a lush condition, if there are any in that condition.

Dr. SCHEELE. In general, one could say that none are in a lush condition. In general we would say that the voluntary schools, the private schools, are in less favorable position than are the State schools. The State schools have fared relatively better due to the fact there are State appropriations for them. The private schools have had some difficulty in raising endowments. Those private

schools which are fortunate enough to be in a State like Pennsylvania, where the State legislature appropriates funds for the private schools, are, of course, better off than their fellow schools in States where they do not get any State assistance.

REVISED BED OCCUPANCY SCHEDULE FOR CLINICAL CENTER

Mr. BUSBEY. Regarding this recruitment program for the clinical center, Dr. Scheele, it appears that the original plan was that if the hospital could have been opened the first of April this year, you would have had 300 beds occupied by July 1, 1954.

Dr. SEBRELL. That is correct.

Mr. BUSBEY. And under the revised budget it is estimated that there will be 250 instead of 300 by July 1, 1954?

Dr. SEBRELL. That is correct.

Mr. BUSBEY. If you had the funds available is there any particular reason why the occupancy would have to be limited to 250 by July 1, 1954, or do you think, even after getting this late start that you could have and should have 300 beds occupied?

Dr. SEBRELL. I feel it would be better to have 300 beds and better to build up at a faster rate. As I indicated earlier, it is also the rate of buildup that is important as well as the total number of beds. You see, I will have to take in just a few patients, say, in the first quarter, and perhaps a few more patients in the second quarter. We cannot build too fast because we have all these things I indicated here. We will have to try out the plant, in a sense, and get the teams organized so the expenses in the first quarter will be low and very properly so, but the rate of buildup after that could probably be faster than is now anticipated, which necessitates more funds from the best we can estimate, and it does mean some more beds. I would not try to go beyond 300 beds in the coming year.

Mr. BUSBEY. The original plan was to arrive at 300 beds over a 15-month period.

Dr. SEBRELL. That is correct.

Mr. BUSBEY. And you now believe that you can arrive at 300 beds in 12 months rather than 15 months, and do it in keeping with the quality of service and research activities that I know you would want to establish?

Dr. SEBRELL. Yes.

Mr. BUSBEY. There is no secret about my position with respect to the center. I want to see it used to capacity just as soon as possible, consistent with good operations in every respect.

I received in the mail this morning from the United States Civil Service Commission Board of Examiners a bulletin announcing examinations for professional nurses for the Clinical Center. Is this the first advertising for examinations for hospital personnel?

Dr. SEBRELL. I am not sure whether that is the first advertisement or not, Mr. Chairman. It probably is. I cannot be certain of that. We have on hand a large number of applications from nurses who have written us from all over the United States, all the way from Alaska to Puerto Rico, applying for jobs at the Clinical Center. I think that we must have 200 or more applications from people who wrote in, having heard the Clinical Center was being organized. I can easily

find out. It just happens I haven't the information. I would be glad to furnish it for the record.

Mr. BUSBEY. In your opinion, if the freeze had not been imposed by the Bureau of the Budget, there would not have been any question about whether or not you could have opened around April 1?

Dr. SEBRELL. Oh, no. We would have opened sometime in April, beyond any question.

Mr. BUSBEY. Our distinguished member, Mr. Fogarty, made reference to the money that was spent on the international wheat program and other programs to sustain certain segments of our society. I just want the record to show that I concur in the statements that Mr. Fogarty made in that respect. I would much rather see funds go into these programs of the National Institutes of Health. If the Congress had followed my votes on appropriations, we would have had a great deal more money available so we would not have to be arguing about a few million for this and a few million for that for the National Institutes of Health.

STATE ASSUMPTION OF RESPONSIBILITY

As far as the States participation in these programs is concerned, I hope that this Congress will be able to give us a substantial Federal tax reduction. Such action will make more money available, or at least more sources of money available at the State level which the States will be able to draw upon in assuming a larger portion of the program than they are now assuming.

I think that the work the Public Health Service has done in the past in originating and promoting many of these programs has been commendatory. I agree with Mr. Fogarty that many of them would never have been started if the Public Health Service had not started them, but now that they have been started I do hope that the States will take recognition of their responsibilities and assume as much of the burden as possible. I appreciate the fact that there are certain programs where it will be necessary that the Federal Government continue to lend its aid and support.

Now, with regard to the cuts in the budget that my good friend from New Mexico, Mr. Fernandez, mentioned earlier in this afternoon's hearing, I want the record to show that, so far as I am concerned, I have never mentioned or discussed a single proposed committee cut in a single budget with a single soul. I can truthfully say that as of this moment I have not made any determination as to the exact appropriation amount I would like to see recommended to the full committee.

Now that the hearings on this appropriation bill have been concluded, I am going to consider every appropriation request very, very carefully. I might say that I do have a record around the Congress for being rather economy minded. I am still going to be economy minded, but I do not have any preconceived ideas about the amounts that should be appropriated in this bill.

Mr. FERNANDEZ. I want the record to show I was not intimating that the gentleman from Illinois had revealed to anyone he intended

to cut this or any other item below the revised budget. My statement had sole reference to what the chairman has been saying in the committee from time to time, which the record shows. It was upon that basis that I assumed further cuts than those recommended by the present Director of the Budget were in the offing on this hospital program and that we should be guarding against it and fighting against it just as hard as we can.

Mr. BUSBEY. I do not believe I have made any reference during the course of the hearings to the question of whether or not reductions below the revised Budget Bureau recommendations should be made. I have from time to time put on the record my own opinion with regard to the necessity for economy and for greater assumption of responsibility by the States.

Mr. FERNANDEZ. That is what I had reference to, Mr. Chairman.

Mr. FOGARTY. You know, Mr. Chairman, if we had cut a few billion dollars more in the last 2 or 3 years we would still be faced with the same problem so far as appropriating funds in this committee is concerned. I will never forget the first year I served in Congress, 1941. I served on the old Claims Committee. We used to have more trouble getting a $5,000 death claim approved by Congress, where, for example, a youngster had been killed by a mail truck; and then by unanimous consent, in the early days of the war, we would appropriate billions of dollars for military purposes. But it was a difficult job to get $5,000 for the family of a child killed by a mail truck.

Mr. BUSBEY. Would my good friend, Mr. Fernandez, be surprised if, when we mark up the bill in executive session, he should find me recommending increases in certain appropriations over the amounts proposed by the Bureau of the Budget?

Mr. FERNANDEZ. I would be very happy to see it in some of these items.

Mr. FOGARTY. I would not be surprised.

Mr. FERNANDEZ. In that case I would extend my apologies to the gentleman, and my congratulations.

Mr. BUSBEY. I want to repeat that right now I do not know what I am going to recommend.

Thank you very much, gentlemen, for coming before the committee and giving us the benefit of your opinions.

Dr. SCHEELE. Thank you, Mr. Chairman. May I say on behalf of the entire Public Health Service that all of our witnesses have been very much impressed by the fairness with which the members of the committee have dealt with us in their hearings this year.

Mr. BUSBEY. We have built up a tremendous hearings record, but we have felt that we did not wish to exclude anyone, whether it was a member of the committee or someone appearing before the committee, from being permitted to include everything in the record he thought was important to our proper consideration of the various budget requests.

Mr. FOGARTY. I would like to say for the record that the chairman has been very fair and lenient with every witness who has appeared before the committee, and I will also make that statement on the floor of the House.

Mr. FERNANDEZ. I wholeheartedly concur in that statement.

APPENDIX A

Summary of Budget Revision

AMERICAN PRINTING HOUSE FOR THE BLIND

No change.

COLUMBIA INSTITUTION FOR THE DEAF

Salaries and Expenses

Amounts available for obligation

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	$413,000	.....	$417,000	.....	$410,000	.....	−$3,000	.....	−$7,000
Additions:										
1. Reimbursements from non-Federal sources	.....	136,200	.....	149,000	.....	149,000	.....	+12,800	.....	.....
Total obligations	.....	549,200	.....	566,000	.....	559,000	.....	+9,800	.....	−7,000
APPLICATION OF FUNDS										
Activities										
1. Instruction and administration:										
(a) Gallaudet College	33	177,709	33	177,709	33	177,709	.....	.....	.....	.....
(b) Kendall School	17	84,200	18	87,700	17	84,200	.....	.....	−1	−3,500
2. Auxiliary services and plant expenses	63	287,291	67	300,591	67	297,091	+4	+9,800	.....	−3,500
Total obligations	113	549,200	118	566,000	117	559,000	+4	+9,800	−1	−7,000

Activity 1 (b). Reduction of $3,500 eliminates request for 1 teacher-librarian.
Activity 2. Reduction of $3,500 eliminates funds for repair of building and miscellaneous repairs.

CONSTRUCTION OF BUILDINGS

Amounts available for obligation

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		$90,000				$41,000		−$49,000		+$41,000
APPLICATION OF FUNDS										
Activities										
Kendall School annex		90,000				41,000		−49,000		+41,000

EXPLANATION

On April 18, 1952, the Board of Education of the District of Columbia advised the Columbia Institution for the Deaf that they had requested the District Commissioners to enter into a contract with the Columbia Institution for the Deaf for the education of all deaf children in the District of Columbia. Heretofore there had been a contract to educate all white children and the new arrangement, thrust upon the institution in an emergency, required residential care and education for about 25 additional colored children for whom there were no facilities.

Estimates were immediately received from the construction firm of Skinker & Garrett to erect 3 rambler-type buildings, 2 for dormitory use and 1 for classroom and dining room quarters, for approximately $79,000. It was planned at that time that these buildings could be made available for college students in the event of any future relocation of Kendall School. An allowance of $11,000 was estimated for equipping and staffing, and a hurried request on May 12, 1952, was made by Congressman Thornberry and Senator Frear for $90,000 for the project. While the regular budget was being heard by the Senate, this amount was approved and appropriated.

Subsequently District Building officials insisted that residential and classroom buildings used for District of Columbia pupils meet certain rigid requirements not provided in the original plans, and new bids covering the required specifications were advertised.

For construction only the high bid was $142,510 and the low and accepted bid was $119,801.

Contracts were entered into after the Board of Directors consented to meet temporarily the extra funds needed.

A statement of all costs, including bringing heat from the central powerplant, is attached showing total of $131,088.06 to be met by the $90,000 appropriation and by $41,088.06 supplemental appropriation.

This does not cover the cost of equipment which is estimated at $5,000 and which should be included in the statement. However, it is felt that this can be absorbed elsewhere.

Construction of buildings, Columbia Institution for the Deaf

Item	*Cost*
Building construction as per Whalen and Purdy contract	$119,801.00
Underground steam lines from gymnasium manhold to buildings as per Thornton contract	3,196.00
Construction of manhole terminal as per Morris and Eagan contract	903.00
Architects' fees to Denton and Wilson	7,188.06
Total obligated costs for construction	131,088.06
By Federal appropriation	90,000.00
By advance from Board funds	41,088.06
Total	131,088.06
1954 request to reimburse the Board	41,000.00

SALARIES AND EXPENSES

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	-------	$5,600,000	-------	$5,663,000	-------	$5,648,000	-------	+$48,000	-------	−$15,000
Reimbursements	-------	54,850	-------	61,150	-------	61,150	-------	+6,300	-------	-------
Total obligations	-------	5,654,850	-------	5,724,150	-------	5,709,150	-------	+54,300	-------	−15,000
APPLICATION OF FUNDS										
Activities										
1. General enforcement operations	890	5,290,150	904	5,353,150	901	5,338,150	+11	+48,000	−3	−15,000
2. General administration	74	309,850	74	309,850	74	309,850	-------	+6,300	-------	-------
3. Reimbursements [1]	6	54,850	6	61,150	6	61,150	-------	-------	-------	-------
Total obligations	970	5,654,850	984	5,724,150	981	5,709,150	+11	+54,300	−3	−15,000

[1] Reimbursements consist of:

	1953	1954
Testing for other agencies	$49,000	$49,000
Proceeds from sale of cars	5,850	12,150
Total	54,850	61,150

NOTE.—The 3 positions and $15,000 decrease in the revised estimate for 1954 represents the 2 statisticians and 1 statistical clerk requested in the original estimate for increased emphasis on the statistical approach to enforcement project planning.

FREEDMEN'S HOSPITAL

SALARIES AND EXPENSES

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	$2,860,750	.....	$3,196,000	.....	$3,104,000	.....	+$243,250	.....	−$92,000
Additions:										
1. Payments received for care of patients	.....	+620,000	.....	+654,000	.....	+734,000	.....	+114,000	.....	+80,000
Total obligations	.....	3,480,750	.....	3,850,000	.....	3,838,000	.....	+357,250	.....	−12,000
APPLICATION OF FUNDS										
Activities										
1. (a) General hospital	436	1,998,406	436	2,349,768	436	2,341,859	0	+343,453	0	−7,909
(b) Tuberculosis hospital	131	568,580	131	567,648	131	563,557	0	−5,023	0	−4,091
2. Outpatient services	79	326,857	79	346,246	79	346,246	0	+19,389	0	0
3. Training program	32	307,498	32	304,217	32	304,217	0	−3,281	0	0
4. Administration	66	279,409	66	282,121	66	282,121	0	+2,712	0	0
Total obligations	744	3,480,750	744	3,850,000	744	3,838,000	0	+357,250	0	−12,000

FACILITIES PLANNING

Item	1953 appropriation (estimate)	Original 1954 estimate	Revised 1954 estimate	Revision compared with—	
				1953 appropriation (estimate)	Original 1954 estimate
Total appropriation or estimate	0	$50,000	0	0	−$50,000

Revision of 1954 estimates

	Direct appropriation	Reimbursements	Total
Original estimate	$3,196,000	$654,000	$3,850,000
Revised estimate	3,104,000	734,000	3,838,000
Difference	−92,000	+80,000	−12,000

EXPLANATION OF CHANGE

Reimbursements

An additional $80,000 in reimbursements have been included in the revised estimate based on current experiences on collections during the first 8 months of fiscal year 1953. A corresponding reduction in funds being requested by direct appropriation has been reflected in the revised estimates.

Activity

(*a*) General Hospital—A decrease of $7,909 has been reflected in the supplies and materials object. Specifically, this decrease is occasioned by a reduction in subsistence requirements owing to a decline in the price of food.

(*b*) Tuberculosis Hospital—A decrease of $4,091 has been reflected in the supplies and materials object. As in the case of the General Hospital, this reduction is specifically shown in subsistence due to a decline in the cost of food.

NOTE.—The revised budget contains no request for the item "Facilities planning" for which the original request was $50,000.

HOWARD UNIVERSITY

Salaries and expenses

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	$2,675,000	.....	$2,750,000	.....	$2,535,000	.....	−$140,000	.....	−$215,000
Additions:										
1. Reimbursements	.....	178,600	.....	178,600	.....	178,600	.....	.....	.....	.....
2. Payments received from non-Federal sources	.....	2,239,164	.....	2,239,164	.....	2,239,164	.....	.....	.....	.....
Total obligations	.....	5,092,764	.....	5,167,764	.....	4,952,764	.....	−140,000	.....	−215,000
APPLICATION OF FUNDS										
1. General administration	106	600,736	106	600,736	106	572,119	.....	−28,617	.....	−28,617
2. Resident instruction and organized research	523	2,666,930	523	2,666,930	523	2,515,054	.....	−151,876	.....	−151,876
3. General library	23	101,807	23	101,807	23	96,583	.....	−5,224	.....	−5,224
4. Operation and maintenance of physical plant	145	687,169	145	762,169	145	732,886	.....	+45,717	.....	−29,283
5. Auxiliary enterprises and noneducational expense	161	1,036,122	161	1,036,122	161	1,036,122	.....	.....	.....	.....
Total obligations	958	5,092,764	958	5,167,764	958	4,952,764	.....	[1] −140,000	.....	[2] −215,000

[1] $215,000 reduction in salaries offset by $75,000 increase in estimated cost of projects in powerplant, covered in "Operation and maintenance of physical plant activity" (net decrease, $140,000).

[2] The reduction of $215,000 is in the basic salaries of permanent positions, distributed through all activities except auxiliary enterprises and noneducational expense which is financed entirely from non-Federal funds.

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		$30,000		$55,000		$30,000				−$25,000
Additions:										
1. Prior year balance available		+344,872		+12,384		+12,384		−232,488		
Deductions:										
1. Balance available in subsequent years		−12,384						+12,384		
Total obligations		262,488		67,384		42,384		−220,104		−25,000
APPLICATION OF FUNDS										
1. Law-school building		2,360		2,064		2,064		−296		
2. Biology-greenhouse building		2,359		2,064		2,064		−295		
3. Administration building		2,360		2,064		2,064		−296		
4. Men's dormitories		84,409		2,064		2,064		−82,345		
5. Preclinical medical building		157,160		32,064		32,064		−125,096		
6. Pharmacy building		13,840		2,064		2,064		−11,776		
7. Utilities extension				25,000						−25,000
Total obligations		262,488		67,384		42,384		−220,104		[1] −25,000

[1] The reduction of $25,000 is the initial request for planning funds for extension of utilities.

CONSTRUCTION OF BUILDINGS

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		$280,221		$170,000		$170,000		−$110,221		
Additions:										
1. Contract authorization due to escalation provision		1,203,800		503,027		98,887		−1,104,913		−$404,140
2. Prior year balance available:										
(a) Appropriation		3,281,356		2,265,686		2,265,686		−1,015,670		
(b) Contract authorization		8,703,153		8,167,439		8,167,439		−535,714		
Deductions:										
1. Balance available in subsequent years:										
(a) Appropriation		−2,265,686		−1,842,147		−1,842,147		+423,539		
(b) Contract authorization		−8,167,439		−7,642,983		−7,486,443		+680,996		156,540
Total obligations		3,035,405		1,621,022		1,373,422		−1,661,983		−247,600
APPLICATION OF FUNDS										
Activities										
1. Women's dormitories		32,178						−32,178		
2. Engineering building		425,498						−425,498		
3. Powerplant additions		909						−909		
4. Dental-school building		226,682		575,890		575,890		+349,208		
5. Law-school building [1]		10,000		122,100				−10,000		−122,100
6. Biology-greenhouse building		1,503,732		257,532		257,532		−1,246,200		
7. Administration building [2]		10,000		125,500				−10,000		−125,500
8. Men's dormitories		10,001						−10,001		
9. Science hall alterations		12,888		275,000		275,000		+262,112		
10. Pharmacy building		803,517		95,000		95,000		−708,517		
11. Vacuum pump in powerplant				20,000		20,000		+20,000		
12. Turbogenerator in powerplant				150,000		150,000		+150,000		
Total obligations		3,035,405		1,621,022		1,373,422		−1,661,983		−247,600

[1] 1953 estimate of obligation reduced by $1,693,640 due to stop order on construction in fiscal 1953 and deletion of liquidating cash in 1954 estimate.
[2] 1953 estimate of obligation reduced by $1,424,310 due to stop order on construction in fiscal 1953 and deletion of liquidating cash in 1954 estimate.

Construction of Buildings (Liquidation of Contract Authority)

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		$1,061,779		$1,900,000			(1)	−$1,061,779		−$1,900,000
Additions:										
1. Prior year balance available		3,477,374		2,799,639		$2,799,639		−677,735		
Deductions:										
1. Applied to contract authorizations		−1,739,514		−2,430,012		−530,012		−1,209,502		−1,900,000
2. Balance available in subsequent years		−2,799,639		−2,269,627		−2,269,627		−530,012		
Total obligations										

[1] Stop orders affecting law school and administration building obligations in fiscal year 1953 eliminate necessity for liquidating cash of $1,900,000 in fiscal year 1954.

PROMOTION AND FURTHER DEVELOPMENT OF VOCATIONAL EDUCATION

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	$18,673,261	.....	$18,673,261	.....	$14,048,870	.....	−$4,624,391	.....	−$4,624,391
Unobligated balance, estimated savings	.....	[1] −363,765	.....	.....	.....	.....	.....	+363,765	.....	.....
Total obligations	.....	18,309,496	.....	18,673,261	.....	14,048,870	.....	−4,260,626	.....	−4,624,391
APPLICATION OF FUNDS										
Activities										
Grants to States (George-Barden Act)	.....	18,154,762	.....	18,498,261	.....	13,873,870	.....	−4,280,892	.....	−4,624,391
Grants to Hawaii	.....	30,000	.....	30,000	.....	30,000	.....	.....	.....	.....
Grants to Puerto Rico	.....	103,630	.....	105,000	.....	105,000	.....	+1,370	.....	.....
Grants to Virgin Islands	.....	21,104	.....	40,000	.....	40,000	.....	+18,896	.....	.....
Total obligations	.....	18,309,496	.....	18,673,261	.....	14,048,870	.....	−4,260,626	.....	−4,624,391

[1] Represents a more accurate estimate based on most recent information.

GRANTS TO STATES

The $4,624,391 reduction in the original 1954 estimate represents a 25 percent cut based on a policy of gradual reduction in Federal funds over the next several years. It is recommended that language limiting the apportionment for distributive education be deleted and that the amount of $13,873,870 be distributed in accordance with the terms of Vocational Education Act of 1946 (George-Barden Act).

FURTHER ENDOWMENT OF COLLEGES OF AGRICULTURE AND THE MECHANIC ARTS

No Change

Salaries and Expenses

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		$2,960,000		$3,250,000		$2,926,000		−$34,000		−$324,000
APPLICATION OF FUNDS										
Activities										
1. Development of vocational education	66	500,000	66	500,000	60	450,000	−6	−50,000	−6	−50,000
2. Services to State and local school systems:										
(a) School assistance in federally affected areas	136	861,000	136	861,000	132	831,000	−4	−30,000	−4	−30,000
(b) Services to school systems	37	255,000	37	254,320	37	254,320		−680		
(c) Services to elementary and secondary schools	56	385,824	55	384,824	55	384,824	−1	−1,000		
(d) Auxiliary educational services	19	115,675	18	115,675	18	115,675	−1			
3. International educational programs	9	54,203	9	54,203	9	54,203				
4. Services to higher educational institutions	27	202,225	26	202,225	26	202,225	−1			
5. Program development and coordination	8	47,320	6	47,000	4	30,000	−4	−17,320	−2	−17,000
(a) Collection and analysis of statistics	20	128,800	20	128,800	20	128,800				
(b) Reports and technical services	13	106,361	13	106,361	13	95,721		−10,640		−10,640
6. Veterans' educational services			43	292,000	12	92,000	+12	+92,000	−31	−200,000
7. Administration	53	303,592	53	303,592	49	287,232	−4	−16,360	−4	−16,360
Total obligations	444	2,960,000	482	3,250,000	435	2,926,000	−9	−34,000	−47	−324,000

NOTE.—Represents a 10 percent reduction in the original budget estimates for 1954, $200,000 of which is taken in the veterans' educational services activity and $50,000 in activity for vocational education. Balance distributed in other activities.

Payments to School Districts

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	$60,500,000	.....	$70,000,000	.....	$66,500,000	.....	+$6,000,000	.....	−$3,500,000
APPLICATION OF FUNDS										
Activities										
Maintenance and operation of schools	.....	60,500,000	.....	70,000,000	.....	66,500,000	.....	+6,000,000	.....	−3,500,000

PAYMENTS TO SCHOOL DISTRICTS

The revised estimate represents a reduction of $3,500,000 and is predicated on the assumption that there will be a slowdown in defense expenditures which would reduce the migration of workers to defense areas and be reflected in reduced entitlements under Public Law 874. If this assumption is not correct, then the revised estimate may not permit payment of 100 percent entitlements under the law.

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		$195,000,000						−$195,000,000		
APPLICATION OF FUNDS										
Activities										
Grants for school construction		194,250,000				−$900,000		−193,350,000		
Technical services rendered by other agencies		750,000				+900,000		−1,650,000		
Total obligations		195,000,000						−195,000,000		

Language is proposed to increase the amount available under the head "School construction," in the Federal Security Appropriation Act of 1953, to $1,650,000, in order to provide an amount of $900,000 to cover engineering, inspection, and other technical services for the fiscal year 1954 under the school construction program rendered by the Division of Community Facilities and Special Operations of the Housing and Home Finance Agency as required by law.

No increase in appropriation is requested. The amount required for technical services will be deducted from the amount previously shown as available for grants for school construction.

OFFICE OF VOCATIONAL REHABILITATION

SALARIES AND EXPENSES

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	$700,000	.....	$725,000	.....	$690,000	.....	−$10,000	.....	−$35,000
Additions: None.										
Deductions: Comparative transfer to: "Salaries and expenses, Office of the Administrator, FSA"	.....	−9,664	.....	.....	.....	.....	.....	+9,664	.....	.....
Total obligations	.....	690,336	.....	725,000	.....	690,000	.....	−336	.....	−35,000
APPLICATION OF FUNDS										
Activities										
1. Development of rehabilitation services for the handicapped	64	490,075	70	520,188	64	490,298	.....	+223	−6	−29,890
2. Approval of State plans and grants	16	99,868	17	104,385	16	99,779	.....	−89	−1	−4,606
3. Administration	18	100,393	18	100,427	18	99,923	.....	−470	.....	−504
Total obligations	98	690,336	105	725,000	98	690,000	.....	−336	−7	−35,000

NOTE.—The reduction of $35,000 shown in the revised estimate is allocated as follows:
Activity 1. Personal services (6 positions), $26,540; travel, $1,561; other contractual services, $1,288; communications, supplies and equipment, $501; total, $29,890.
Activity 2. Personal services (1 position), $4,292; other objects, $314; total, $4,606.
Activity 3. Personal services, $504.

There is no revision of the amount of $23,000,000 requested under the head, "Payments to States (including Alaska, Hawaii, and Puerto Rico), Office of Vocational Rehabilitation."

Control of venereal diseases

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	-------	$9,850,000	-------	$8,325,000	-------	$6,695,000	-------	−$3,155,000	-------	−$1,630,000
Net transfers	-------	−159,825	-------	0	-------	0	-------	+159,825	-------	0
Total obligations	-------	9,690,175	-------	8,325,000	-------	6,695,000	-------	−2,995,175	-------	−1,630,000
APPLICATION OF FUNDS										
Activities										
1. Grants to States for general venereal disease control, case finding, and treatment	409	8,037,175	299	6,695,000	299	5,195,000	−110	−2,842,175	0	−1,500,000
2. Direct operations:										
(a) Clinical and laboratory research	65	365,000	65	365,000	64	360,000	−1	−5,000	−1	−5,000
(b) Technical assistance to States	155	1,043,000	150	1,020,000	140	910,000	−15	−133,000	−10	−110,000
(c) Administration	32	245,000	32	245,000	30	230,000	−2	−15,000	−2	−15,000
Total obligations	661	9,690,175	546	8,325,000	533	6,695,000	−128	−2,995,175	−13	−1,630,000

Revisions of 1954 estimate

Original estimate	$8,325,000
Revised estimate	6,695,000
Net change	−1,630,000

EXPLANATION OF CHANGE

The reduction of $1,630,000 is distributed as follows:

Activity 1. Grants to States: Reduction of $1,500,000 for laboratory services for venereal diseases, including premarital, prenatal, preemployment and preinduction blood testing and for diagnostic-consultative services to private physicians.

Activity 2. Clinical and laboratory research: Personal services (1 position) $4,000, travel $500, other objects $500.

Activity 2b. Technical assistance to States: Personal services (10 positions) $68,000, travel $17,000, other objects $25,000. This is based on curtailment of consultative services to States from regional offices and of special assistance to State health departments in venereal-disease control, including services involved in arranging for the planned shift from an in-patient to an out-patient treatment basis. Special surveys to clear out pockets of venereal disease in particular areas will also be curtailed.

Activity 2c. Administration: Personal services (2 positions) $10,000, travel $3,000, other objects $2,000.

Control of Tuberculosis

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		$8,240,000		$7,645,000		$5,725,000		−$2,515,000		−$1,920,000
Deductions:										
1. Comparative transfer to: "Salaries and expenses, Public Health Service"		−18,000		0		0		+18,000		0
Total obligations		8,222,000		7,645,000		5,725,000		−2,497,000		−1,920,000
APPLICATION OF FUNDS										
Activities										
1. Grants to States for tuberculosis control activities		5,300,000		5,300,000		4,000,000		−1,300,000		−1,300,000
2. Direct operations:										
(a) Cooperative applied research	149	915,400	149	915,000	143	875,000	−6	−40,400	−6	−40,000
(b) Technical assistance to States	232	1,787,480	181	1,211,000	181	680,000	−51	−1,107,480	0	−531,000
(c) Administration	40	219,120	40	219,000	29	170,000	−11	−49,120	−11	−49,000
Total obligations	421	8,222,000	370	7,645,000	353	5,725,000	−68	−2,497,000	−17	−1,920,000

Revision of 1954 estimate

Original estimate	$7,645,000
Revised estimate	5,725,000
Net change	−1,920,000

EXPLANATION OF CHANGE

The reduction of $1,920,000 is distributed as follows:

Activity 1: Grants to States: A reduction of $1,300,000 in funds available to States for tuberculosis-control programs, including chest X-ray case finding, tuberculosis clinic operations, public-health home nursing services, and laboratory diagnostic services.

Activity 2 (*a*): Cooperative applied research: Personal services (6 positions) $34,530, travel $4,020, other objects $1,450. The reduction results from the completion of the field phase of the epidemiology study at Philadelphia.

Activity 2 (*b*): Technical assistance to States: Personal services $272,566, travel $123,956, other objects $134,478. Will terminate the mass X-ray surveys in large cities with the completion of the Pittsburgh survey in September 1953, which will bring to an end this program.

Activity 2 (*c*): Administration: Personal services (11 positions) $36,326, travel $1,074, other objects $11,600. This reduction will be made by the curtailment of case-finding activities.

Assistance to States, General

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		$16,150,000		$16,315,000		$16,215,000		+$65,000		−$100,000
Additions:										
1. Transfer from: "Control of venereal diseases, Public Health Service"		+50,000		0		0		−50,000		0
Total direct obligations		16,200,000		16,315,000		16,215,000		+15,000		−100,000
APPLICATION OF FUNDS										
Activities										
1. Grants to States for general health		13,000,000		13,000,000		13,000,000		0		0
2. Direct operations:										
(a) Technical assistance to States	325	2,035,900	324	2,026,000	304	1,928,000	−21	−107,900	−20	−98,000
(b) Vital statistics	195	1,056,900	235	1,182,000	235	1,180,000	+40	+123,100	0	−2,000
(c) Administration	24	107,200	24	107,000	24	107,000	0	−200	0	0
Total direct obligations	544	16,200,000	583	16,315,000	563	16,215,000	+19	+15,000	−20	−100,000

Revisions of 1954 estimate

Original estimate	$16,315,000
Revised estimate	16,215,000
Net change	−100,000

EXPLANATION OF CHANGE

The reduction of $100,000 is distributed as follows:

Activity 2: Technical assistance to States: Personal services (20 positions), $80,000; travel, $14,495; and other objects, $3,505. The reduction is based primarily on curtailment of consultative services to States from regional offices and the central office.

Activity 3: Vital statistics: Travel, $2,000.

Control of Communicable Diseases

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		$5,919,750		$5,735,000		$5,335,000		−$584,750		−$400,000
Deductions:										
1. Comparative transfers to: Salaries and expenses, Public Health Service		−15,000		0		0		+15,000		0
Total direct obligations		5,904,750		5,735,000		5,335,000		−569,750		−400,000
APPLICATION OF FUNDS										
Activities										
1. General disease-prevention and control activities	846	4,151,700	831	4,100,000	809	3,968,300	−37	−183,400	−22	−131,700
2. Specific disease-prevention and control activities	272	1,216,050	253	1,100,000	196	851,700	−76	−364,350	−57	−248,300
3. General epidemic and disaster aid		40,000		40,000	0	40,000	0	0	0	0
4. Administration	124	497,000	123	495,000	116	475,000	−8	−22,000	−7	−20,000
Total direct obligations	1,242	5,904,750	1,207	5,735,000	1,121	5,335,000	−121	−569,750	−86	−400,000

Revisions of 1954 estimate

Original estimate	$5,735,000
Revised estimate	5,335,000
Net change	−400,000

EXPLANATION OF CHANGE

The reduction of $400,000 is distributed as follows:

Activity 1: General disease—prevention and control activities: Personal services (22 positions), $81,200; travel, $18,700; other objects, $31,800. The reduction will result in the elimination of research on laboratory phases of nursing techniques and investigations on the airborne aspects of the transmission of diarrheal diseases of infants in hospitals. Also, it will result in the curtailment of training of public-health personnel and production of training materials.

Activity 2: Specific disease—prevention and control activities: Personal services (57 positions), $191,600; travel, $8,800; other objects, $47,900. The reduction will make necessary a contraction in investigations and demonstrations on the prevention and control of dysentery and other diarrheal diseases, typhus fever, plague, and other rat-borne diseases, the curtailment of investigations on poliomyelitis, and the discontinuance of studies on the transmission of "Q" fever.

Activity 4: Administration: Personal services (7 positions), $18,800; other objects, $1,200. The decrease reflects a reduction in administrative services in accordance with the curtailment of program activities.

ENGINEERING, SANITATION, AND INDUSTRIAL HYGIENE

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	$3,700,000	.....	$3,985,000	.....	$3,850,000	.....	+$150,000	.....	−$135,000
APPLICATION OF FUNDS										
Activities										
1. Industrial hygiene	108	644,000	108	644,000	108	641,000	0	−3,000	0	−3,000
2. Environmental research activities	85	442,000	107	620,000	106	604,200	+21	+162,200	−1	−15,800
3. Water supply and water pollution control	199	1,300,000	207	1,360,000	191	1,297,000	−8	−3,000	−16	−63,000
4. Radiological health services	45	356,000	46	355,000	46	353,000	+1	−3,000	0	−2,000
5. General sanitation activities	131	837,000	140	885,000	131	835,000	0	−2,000	−9	−50,000
6. Administration	27	121,000	27	121,000	27	119,800	0	−1,200	0	−1,200
Total direct obligations	595	3,700,000	635	3,985,000	609	3,850,000	+14	+150,000	−26	−135,000

Revisions of 1954 estimate

Original estimate	$3,985,000
Revised estimate	3,850,000
Net change	−135,000

EXPLANATION OF CHANGE

The reduction of $135,000 is distributed as follows:

Activity 1. Industrial hygiene: Reduction of $3,000 in travel.

Activity 2. Environmental research activities: Personal services (1 position), $3,000; travel, $3,000; other objects, $9,800. The reduction will result in some slight curtailment of research operations in the new environmental Health Research Center.

Activity 3. Water supply and water pollution control: Personal services (16 positions), $52,850; travel, $8,000; other objects, $2,150. The reduction eliminates the increases requested for strengthening the enforcement program, and requires rephasing of some comprehensive river basin surveys over a longer period of time.

Activity 4. Radiological health services: Travel, $1,900; other objects, $100.

Activity 5. General sanitation activities: Personal services (9 positions), $40,000; travel, $6,800; other objects, $3,200. The reduction eliminates the increase proposed for initiation of the program to control the interstate transmission of swine diseases affecting human health.

Activity 6. Administration: Travel, $700; other objects, $500.

GRANTS, WATER POLLUTION CONTROL

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	0	.....	$900,000	.....	0	.....	0	.....	−$900,000
APPLICATION OF FUNDS										
Activity										
1. Grants to States and interstate agencies for industrial waste studies, surveys, and research	.....	0	.....	900,000	.....	0	.....	0	.....	−900,000

Disease and sanitation investigations and control, Territory of Alaska

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		$1,107,500		$1,107,000		$1,082,000		−$25,500		−$25,000
APPLICATION OF FUNDS										
Activities										
1. Special grant to Alaska for general health purposes	0	540,000	0	540,000	0	540,000	0	0	0	0
2. Direct operations:										
(a) Technical assistance to Alaska	18	118,000	15	118,000	14	108,000	−4	−10,000	−1	−10,000
(b) Field and laboratory investigations	44	387,100	44	387,000	42	372,000	−2	−15,100	−2	−15,000
(c) Administration	9	62,400	9	62,000	9	62,000	0	−400	0	0
Total obligations	71	1,107,500	68	1,107,000	65	1,082,000	−6	−25,500	−3	−25,000

Revisions of 1954 estimate

Original estimate	$1,107,000
Revised estimate	1,082,000
Net change	−25,000

EXPLANATION OF CHANGE

The reduction of $25,000 is distributed as follows:

Activity 1: Technical assistance to Alaska: Personal services (1 position) $10,000. The reduction will result in less assistance provided the Alaska Department of Health.

Activity 2: Field and laboratory investigations: Personal services (2 positions), $7,700; travel, $2,300; other objects $5,000. The reduction will result in elimination of supporting personnel and some curtailment of program operations.

Grants for Hospital Construction

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	-------	$75,000,000	-------	$75,000,000	-------	$60,000,000	-------	−$15,000,000	-------	−$15,000,000
APPLICATION OF FUNDS										
Activities										
1. Grants for hospital construction	-------	75,000,000	-------	75,000,000	-------	60,000,000	-------	−15,000,000	-------	−15,000,000

Revision of 1954 estimate

Original estimate	$75,000,000
Revised estimate	60,000,000
Net change	−15,000,000

Explanation of change

The reduction of $15,000,000 under this appropriation will reduce by 1,875 the number of hospital beds and public health centers which can be provided. It is pertinent to indicate what may be accomplished with an appropriation of $60,000,000 in 1954. This amount would be matched by State and local money for a total program of approximately $120,000,000. At an average cost figured at $16,000 each, 7,500 hospital beds would be provided plus a few public health centers and related health facilities.

Thirty of the States, in order to get essential larger projects under way, have projected financing of hospitals and other projects into future years, based on an anticipated Federal appropriation of $75,000,000 annually. In some of these States their share of a $60,000,000 appropriation will not be sufficient to cover the amounts they have planned to use in this manner.

Grants for Hospital Construction (Liquidation of Contract Authorization)

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	$59,700,000	.....	$19,804,000	.....	$19,700,000	.....	−$40,000,000	.....	−$104,000
APPLICATIONS OF FUNDS										
Activities										
1. Liquidation of contract authorization	.....	59,700,000	.....	19,804,000	.....	19,700,000	.....	−40,000,000	.....	−104,000

Revision of 1954 estimate

Original estimate	$19,804,000
Revised estimate	19,700,000
Net change	−104,000

EXPLANATION OF CHANGE

Under the appropriation "Grants for hospital construction, Public Health Service" authorizations totaling $542,500,000 have been made available by the Congress for the hospital survey and construction program in the form of contract authorizations and obligational cash. Through 1953 the Congress has appropriated $522,200,000 under that appropriation. This leaves a balance of $20,300,000.

It is not necessary that all of that balance be appropriated since in a few instances, the States have not utilized every dollar allocated to them and small amounts of money have accumulated on behalf of the Government as final audits were completed for the projects.

The printed budget indicates that $19,804,000 is required for the liquidation of obligations incurred under the contractual authorizations for 1948 through 1951. Several months have elapsed since the estimate was prepared and careful review of the request discloses that the request can be reduced by $104,000 to a new total of $19,700,000.

Salaries and Expenses, Hospital Construction Services

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		$1,200,000		$1,200,000		$1,125,000		−$75,000		−$75,000
APPLICATION OF FUNDS										
Activities										
1. Operations and technical services activities	162	1,090,440	162	1,090,440	154	1,021,000	−8	−69,440	−8	−69,440
2. Administration	23	109,560	23	109,560	22	104,000	−1	−5,560	−1	−5,560
Total obligations	185	1,200,000	185	1,200,000	176	1,125,000	−9	−75,000	−9	−75,000

Revision of 1954 estimate

Original estimate	$1,200,000
Revised estimate	1,125,000
Net change	−75,000

EXPLANATION OF CHANGE

The reduction of $75,000 is distributed as follows:

Activity 1. Operations and technical services activities: Personal services (8 positions), $54,097; travel, $6,240; transportation of things, $450; printing and reproduction, $2,000; other contractual services, $1,700; supplies and materials, $900; equipment, $4,050; and taxes and assessment, $3. The reduction of $69,440 for personal services and other objects under this activity will limit the services that are being provided from the regional offices to the States and project applicants under the hospital survey and construction program by specialists in the fields of programming, planning, design, construction, and equipment of hospitals, public health centers, and related health facilities. This includes the transferring of the duties and functions of the hospital construction staff from Region IV, Cleveland, Ohio, to Region V, Chicago, Ill.

Activity 2. Administration: Personal services (1 position), $5,060; travel, $260; transportation of things, $50; supplies and materials, $100; and equipment, $90. The reduction of $5,560 will reduce staff utilized to maintain current information and data required in budget preparation and execution.

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	$33,688,000	.....	$35,224,000	.....	$33,551,000	.....	−$137,000	.....	−$1,673,000
Additions:										
1. Reimbursements	.....	5,306,600	.....	5,075,000	.....	3,460,000	.....	−1,846,600	.....	−1,615,000
2. Net transfers	.....	295,000	.....	0	.....	0	.....	−295,000	.....	0
Total obligations	.....	39,289,600	.....	40,299,000	.....	37,011,000	.....	−2,278,600	.....	−3,288,000
APPLICATION OF FUNDS										
Activities										
1. Operation of hospitals	6,860	31,324,600	6,542	31,768,300	6,152	29,064,000	−708	−2,260,600	−390	−2,704,300
2. Operation of outpatient clinics	489	4,376,000	489	4,275,300	515	4,412,000	+26	+36,000	+26	+136,700
3. Operation of health units	75	340,000	75	340,400	75	340,400	0	+400	0	0
4. Coast Guard medical services	95	994,500	95	979,400	95	969,400	0	−25,100	0	−10,000
5. Development and coordination of nursing resources	21	90,000	21	90,000	21	90,000	0	0	0	0
6. Personnel detailed to other agencies	153	981,100	153	1,017,100	153	1,017,100	0	+36,000	0	0
7. Payments to Hawaii	0	500,000	0	1,182,300	0	500,000	0	0	0	−682,300
8. Administration	117	683,400	117	646,200	117	618,100	0	−65,300	0	−28,100
Total obligations	7,810	39,289,600	7,492	40,299,000	7,128	37,011,000	−682	−2,278,600	−364	−3,288,000

EXPLANATION OF CHANGE

The total reduction of $3,288,000 in obligations is composed of the following:

1. *Reimbursements.*—A decrease in reimbursements of $1,615,000 based on the loss of 300 veteran patients has been reflected in the revised funds available.

2. *Appropriated funds.*—A decrease of $1,673,000 in appropriated funds.

Before discussing the requirements for 1954, it is necessary to explain that after the beginning of 1953 a reduction in reimbursable veteran patients caused a loss of over a million dollars in reimbursable funds which forced the conversion of four hospitals to clinic status in order to contain obligations within available funds. It was further necessary to curtail equipment purchases, reduce supply inventories, and drastically reduce the staff in the remaining hospitals. The effect of this situation in 1953 carries over to these estimates as a continuation of the depressed level of operations that was forced on the hospitals by the financial situation described above.

Specific actions involved in the revised presentation are described by activity below:

Activity 1. Operation of hospitals

The reduction of $2,704,300 represents the following proposed actions:

(*a*)	Reduction in average employment of 479 man-years	$1,739,400
(*b*)	Reduction of unit allowances for supplies by 3 percent	59,000
(*c*)	Reduction of unit cost of rations by 3 cents	79,000
(*d*)	Further reduction of supplies and materials inventories	208,000
(*e*)	Reduction of equipment to the 1953 allowance	306,000
(*f*)	Net effect of workload adjustments, and other changes in minor objects	312,900
	Total reduction	2,704,300

Activity 2. Operation of outpatient clinics and offices

In 1954, although there was a requirement to carry on a full-year basis the 4 converted clinics, the original request proposed a reduction of $100,700. That estimate is now revised upward by $136,700 to provide for an additional clinic. The total cost of that clinic is estimated at $180,000 which is partially offset by a reduction of $43,300 in the remainder of this activity.

Activity 4. Coast Guard medical services

The decrease of $10,000 in this activity will result in a reduction in the average employment of personnel providing medical care to the Coast Guard.

Activity 7. Payments to Hawaii

The reduction of $682,300 proposes to continue support at the 1953 level of $500,000 reimbursements to the Territory of Hawaii for the care of persons afflicted with leprosy.

Activity 8. Administration

The reduction of $28,100 in administration when added to the previously proposed reduction of $37,200 from the 1953 level represents a total cut of $65,300 from the current level of this activity.

Foreign Quarantine Service

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		$3,065,000		$3,100,000		$3,050,000		−$15,000		−$50,000
APPLICATION OF FUNDS										
Activities										
Medical examination of aliens and quarantine inspection of persons, vessels, and aircraft entering United States ports	495	2,556,000	495	2,556,000	495	2,542,000	0	−14,000	0	−14,000
Medical examination of visa applicants in foreign countries	75	337,000	75	372,000	75	337,000	0	0	0	−35,000
Administration	33	172,000	33	172,000	33	171,000	0	−1,000	0	−1,000
Total obligations	603	3,065,000	603	3,100,000	603	3,050,000	0	−15,000	0	−50,000

Revisions of 1954 estimate

Original estimate	$3,100,000
Revised estimate	3,050,000
Net change	−50,000

EXPLANATION OF CHANGE

The reduction of $50,000 is distributed as follows:

Activity 1. Medical examination of aliens and quarantine inspection of persons, vessels, and aircraft entering United States ports: Personal services (3 man-years) $12,600; travel, $1,100; and supplies and materials, $300. The reduction will result in some curtailment of the medical inspections or the screening of persons and things arriving at the United States ports of entry.

Activity 2. Medical examination of visa applicants in foreign countries: Personal services (5 man-years), $30,000; travel, $3,600; transportation of things, $200; and supplies and materials, $1,200. This reduction will not permit coverage by the Public Health Service of the immigration medical examinations at Liverpool, Dublin, and Glasgow and will require curtailment of this program at other consulates.

Activity 3. Administration: Personal services, $400; travel, $300; and supplies and materials, $300.

Operating Expenses, National Institutes of Health

Amounts available for obligation

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	$16,598,750	.....	$5,180,000	.....	$4,675,000	.....	−$11,923,750	.....	−$505,000
Net transfers	.....	−11,588,400	.....	0	.....	0	.....	+11,588,400	.....	0
Total obligations	.....	5,010,350	.....	5,180,000	.....	4,675,000	.....	−335,350	.....	−505,000
APPLICATION OF FUNDS										
Activities										
1. Grants for research and training:										
(a) Research projects	.....	4,255,000	.....	4,500,000	.....	4,000,000	.....	−255,000	.....	−500,000
(b) Research fellowships	.....	199,000	.....	124,000	.....	124,000	.....	−75,000	.....	0
2. Direct operations:										
(b) Other direct operations:										
(1) Review and approval of research and training grants	107	556,350	107	556,000	107	551,000	0	−5,350	0	−5,000
Total obligations from appropriated funds	107	5,010,350	107	5,180,000	107	4,675,000	0	−335,350	0	−505,000

EXPLANATION OF CHANGE

The reduction of $505,000 is distributed as follows:

Activity 1 (*a*). Grants for research projects: A reduction of $500,000. The revised request for 1954 of $4 million provides support for research in medical and related scientific fields not directly pertinent to the program objectives of any of the 7 institutes but of real concern to all of them because of the significant need for a balanced Public Health Service research grants program that affords equitable opportunity for support of the best research in all health and medical fields. Of the $4 million, $3,400,000 will be used for continuation of 378 research projects on which research teams and tools have been assembled and progress is indicated toward returns on investment. The revised estimate will permit support of 75 new research projects in place of 134 provided for in the original estimate.

Activity 2 (*b*) 1. Review and approval of research and training grants: The reduction of $5,000 in this activity will require decreased travel by professional staff members on project site visits at grantee laboratories, with a resultant less complete acquisition of data considered important to the adequate evaluation of requests for grants.

Reimbursable activities

Original estimate	$7,912,300
Revised estimate	6,790,800
Net change	−1,121,500

EXPLANATION OF CHANGE

The reduction of $1,121,500 is distributed as follows:

Activity 2 (*a*) 1. Clinical center services to laboratory and patient areas: A reduction of $914,500 involving personal services (176 positions) $723,400; travel, $11,000; communication services, $7,300; supplies and materials, $166,400; other expenses, $6,400. The date for admitting patients has been changed from April 1 to July 1, 1953. Under the revised plan for bed activation, we will be starting with 0 beds instead of 150 beds on July 1, 1953, and build up to 240 beds instead of 300 beds on June 30, 1954. There will be a corresponding reduction in the total volume of clinical research during 1954.

Activity 2 (*a*) 2. Research services: Reduction of $197,000 applied to personal services (30 positions), $97,100; supplies and materials, $56,900; equipment, $11,000; rents and utilities, $23,000; other expenses, $9,000.

The revised estimate makes necessary a reduction in laboratory research services of 15 positions and $80,000. Production of experimental animals will be cut back and a calculated risk will be taken in reducing sanitation measures designed to keep animals disease-free. A lesser amount of sterile laboratory glassware will be available to scientists.

The reduction in scientific reports services of 7 positions and $40,000 will eliminate 2 translating positions, 1 research writer, 1 clinical research librarian, 1 position for receiving visitors, and 2 clerical positions. Binding of periodicals for the library will be reduced $5,000.

The reduction in research plant and equipment services of 8 positions and $77,000 will reduce personnel in the central shops fabricating items for the scientists. The estimate for supplies and utilities is reduced $43,000. $7,000 for purchase of 5 automobiles for replacement has been eliminated.

A large proportion of funds under this activity are required for fixed costs related to building and equipment operations. Since there has been no experience in operating the clinical center and other new facilities, adjustments may be necessary in the way reductions are applied under operating conditions.

Activity 2 (*b*) 2. Administration: A reduction of $10,000 is made by reducing 2 positions.

Salaries, Expenses, and Grants, National Cancer Institute

Amounts available for obligation

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		$17,887,000		$22,000,000		$15,780,000		−$2,107,000		−$6,220,000
Net transfers		−367,800		0		0		+367,800		0
Total obligations		17,519,200		22,000,000		15,780,000		−1,739,200		−6,220,000
APPLICATION OF FUNDS										
Activities										
1. Grants:										
(a) For research and training:										
1. Research projects		4,750,000		4,734,000		4,734,000		−16,000		0
2. Research fellowships		625,000		514,000		514,000		−111,000		0
3. Teaching of medical subjects		2,225,000		2,225,000		1,625,000		−600,000		−600,000
4. Training stipends		500,000		500,000		300,000		−200,000		−200,000
5. Construction of research facilities		0		4,000,000		0		0		−4,000,000
(b) For detection, diagnosis, and other control services		3,050,000		3,000,000		2,250,000		−800,000		−750,000
(c) For special control projects		900,000		900,000		900,000		0		0
2. Direct operations:										
(a) Research	532	4,617,600	525	5,277,000	521	4,669,000	−11	+51,400	−4	−608,000
(b) Other direct operations:										
1. Technical assistance to States	79	400,000	79	400,000	71	353,000	−8	−47,000	−8	−47,000
2. Review and approval of grants	15	108,000	15	100,000	14	96,000	−1	−12,000	−1	−4,000
3. Administration	22	343,600	22	350,000	22	339,000	0	−4,600	0	−11,000
Total obligations	648	17,519,200	641	22,000,000	628	15,780,000	−20	−1,739,200	−13	−6,220,000

EXPLANATION OF CHANGE

The reduction of $6,220,000 is distributed as follows:

Activity 1 (*a*) 3. Grants for teaching of medical subjects: $600,000. The reduction will result in either the discontinuance of support for a large number of schools and/or a marked decrease in the amount of support for 4-year medical schools, i. e., those now receiving the larger grants. The impact of this reduction is of such importance to the teaching programs of the medical schools that final decision on its application will be delayed until nongovernmental advisory panels have had opportunity to consider.

Activity 1 (*a*) 4. Training stipends: $200,000. The decrease will reduce annual appointments of trainees from approximately 139 to approximately 83. About 40 percent of the program will be eliminated.

Activity 1 (*a*) 5. Grants for construction of research facilities: $4,000,000. The deletion of this item will defer needed expansion of research facilities throughout the Nation.

Activity 1 (*b*). Grants for detection, diagnosis, and other control services: $750,000. This reduction will result in an appreciable retrenchment in State Health department cancer control programs.

Activity 2 (*a*). Research: $608,000. Personal services (4 positions), $73,000; travel, $6,300; reimbursement to "Operating expenses, National Institutes of Health," $300,700 for clinical center and other central services as described under that appropriation; supplies and materials, $115,000; equipment, $111,000; other objects, $2,000. The decrease results in great part from a later opening date for the clinical center and a lesser number of beds available during the fiscal year. These beds will be activated at a slower rate than previously anticipated. Four positions will be eliminated and the procurement of some supplies and equipment will be deferred for a time.

Activity 2 (*b*) 1. Technical assistance to States: $47,000. Personal services (8 positions), $37,000; travel, $3,000; other contractual services, $2,000; equipment, $5,000. Consultative services to institutions, teaching centers, detection clinics, professional organizations and to State and local health agencies will be reduced. This reduction will eliminate a portion of the program relating to the early discovery and diagnosis of cancer in the population.

Activity 2 (*b*) 2. Review and approval of grants: Personal services (1 position), $4,000.

Activity 2 (*b*) 3. Administration: $11,000. Other contractual services, $2,000; reimbursement to "Operating expenses, National Institutes of Health," $6,000; supplies and materials, $2,000; equipment, $1,000. This reduction is occasioned by the delay in the opening and operation of the clinical center.

Mental Health Activities

Amounts available for obligation

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with— 1953 appropriation (estimate)		Revision compared with— Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		$10,895,000		$15,500,000		$9,817,000		−$1,078,000		−$5,683,000
Net transfers		−76,000		0		0		+76,000		0
Total direct obligations		10,819,000		15,500,000		9,817,000		−1,002,000		−5,683,000
APPLICATION OF FUNDS										
Activities										
1. Grants:										
(a) For research and training:		[1] 1,649,022		2,665,000		1,649,000		−22		−1,016,000
1. Research projects		250,000		187,000		187,000		−63,000		0
2. Research fellowships		3,676,000		4,176,000		3,051,000		−625,000		−1,125,000
3. Training grants		0		2,500,000		0		0		−2,500,000
4. Construction of research facilities										
(b) For detection, diagnosis, and other preventive and control services		3,100,000		3,100,000		2,325,000		−775,000		−775,000
2. Direct operations:	141	1,295,300	163	1,990,000	160	1,785,000	+19	+489,700	−3	−205,000
(a) Research										
(b) Other direct operations:										
1. Review and approval of research and training grants	15	130,000	15	130,000	14	120,000	−1	−10,000	−1	−10,000
2. Training activities	11	70,000	11	70,000	9	60,000	−2	−10,000	−2	−10,000
3. Technical assistance to States	59	398,000	59	398,000	54	361,000	−5	−37,000	−5	−37,000
4. Administration	34	314,700	34	284,000	33	279,000	−1	−35,700	−1	−5,000
Total funds for program performance	260	10,883,022	282	15,500,000	270	9,817,000	+10	−1,066,022	−12	−5,683,000
Adjustment for obligations incurred in advance of program performance		[1] −64,022		0		0		+64,022		0
Total direct obligations		10,819,000		15,500,000		9,817,000		−1,002,000		−5,683,000

[1] Some of the obligations for grants for research projects were incurred several years in advance of actual program performance. By means of the adjustment line shown in this schedule, the amounts by activity reflect the actual performance levels for each year.

EXPLANATION OF CHANGE

The reduction of $5,683,000 is distributed as follows:

Activity 1 (*a*) 1: Grants for research projects, $1,016,000. The revised 1954 estimate reduces by 50 the number of investigations to be conducted by scientists throughout the country who are engaged in research on mental illness and mental health.

Activity 1 (*a*) 3: Training grants, $1,125,000. The revised estimate provides a $625,000 decrease below the 1953 program level. It is estimated that the revised budget will reduce the number of persons that can be trained in mental health specialties by about 15 percent, and will make difficult the continuance of teaching programs in psychiatric specialties in almost one-quarter of the schools receiving grants.

Activity 1(*a*) 4: Grants for construction of research facilities, $2,500,000. The proposal for a program of construction grants is omitted in the revised estimate.

Activity 1 (*b*): Grants for detection, diagnosis, and other preventive and control services, $775,000. Formula grants to the States are decreased 25 percent. The effect of the reduction is that an additional 15,000 individuals will be added to the waiting lists of mental health clinics, and in about 18 States where the mental health program is new, continuance of a sound program will be difficult.

Activity 2 (*a*): Research, $205,000. Personal services (3 positions) $13,000; travel, $10,500; other contractual services, $2,500; reimbursement to "Operating expenses, National Institutes of Health" for Clinical Center and other research services, $176,800; other expenses, $2,200. The revised estimate provides for operations in the Clinical Center—both laboratory and clinical research—at a lower level of activity in 1954 than originally planned owing to the slower rate of bed activation.

Activity 2 (*b*) 1: $10,000. Review and approval of research and training grants: Personal services (1 position and consultant fees), $8,800; travel, $1,000; communication services, $200. In addition to reduction of one position, the estimate provides for less use of consultants to advise on the grants programs. Although there is a substantial decrease in the estimates for research and training grants, workload is more related to volume of applications than to volume of approved and paid grants.

Activity 2 (*b*) 2: Training activities, $10,000. Personal services (2 positions), $9,600; transportation of things, $200; communication services, $200. Training of Public Health Service personnel in specialties important to mental health will be reduced.

Activity 2 (*b*) 3: Technical assistance to States, $37,000. Personal services (5 positions), $36,700; supplies and materials, $200; equipment, $100. The revised estimate provides for a lesser amount of consultative services on matters relating to basic mental health services and on such problems as alcoholism, juvenile delinquency, school mental health programs, and rehabilitation of mental patients. Professional consultants in the field will be reduced about 20 percent.

Activity 2 (*b*) 4: Administration, $5,000. Personal services (1 position), $4,000; other contractual services, $600; supplies and materials, $400.

Salaries, Expenses, and Grants, National Heart Institute

Amounts available for obligation

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	$12,000,000	.....	$16,500,000	.....	$11,040,000	.....	−$960,000	.....	−$5,460,000
Net transfers	.....	−225,000	.....	0	.....	0	.....	+225,000	.....	0
Total obligations	.....	11,775,000	.....	16,500,000	.....	11,040,000	.....	−735,000	.....	−5,460,000
APPLICATION OF FUNDS										
Activities										
1. Grants:										
(a) For research and training:										
1. Research projects	.....	4,927,000	.....	5,070,000	.....	4,927,000	.....	0	.....	−143,000
2. Research fellowships	.....	450,000	.....	357,000	.....	357,000	.....	−93,000	.....	0
3. Teaching of medical subjects	.....	1,373,000	.....	1,373,000	.....	1,023,000	.....	−350,000	.....	−350,000
4. Training stipends	.....	250,000	.....	250,000	.....	125,000	.....	−125,000	.....	−125,000
5. Construction of research facilities	.....	0	.....	4,000,000	.....	0	.....	0	.....	−4,000,000
(b) For detection, diagnosis, and other control activities	.....	1,500,000	.....	1,500,000	.....	1,125,000	.....	−375,000	.....	−375,000
2. Direct operations:	334	2,615,400	334	3,322,000	334	2,914,000	0	+298,600	0	−408,000
(a) Research	13	90,100	13	90,000	13	86,000	0	−4,100	0	−4,000
(b) Other direct operations:										
1. Review and approval of grants	57	345,000	57	345,000	50	297,000	−7	−48,000	−7	−48,000
2. Technical assistance to States	12	224,500	12	193,000	12	186,000	0	−38,500	0	−7,000
3. Administration										
Total obligations	416	11,775,000	416	16,500,000	409	11,040,000	−7	−735,000	−7	−5,460,000

EXPLANATION OF CHANGE

The reduction of $5,460,000 is distributed as follows:

Activity 1 (*a*) 1: Grants for research projects, $143,000. This reduction creates an inability to support some 14 projects for research in cardiovascular diseases throughout the country.

Activity 1 (*a*) 3: Grants for teaching of medical subjects, $350,000. The Heart Institute has a teaching grant program for 1953 committed to the extent of $1,341,294. This includes support of some 78 medical schools and special grants, including rehabilitation. A reduction of funds to the extent of $350,000 in this program below the level provided in 1953 and originally projected for 1954 will necessitate a parceling of reduction among the various schools participating in this program.

Activity 1 (*a*) 4: Training stipends, $125,000. The reduction of 50 percent in this activity represents elimination of support for specialized training to approximately 37 candidates in the cardiovascular field.

Activity 1 (*a*) 5: Grants for construction of research facilities, $4 million. The elimination of these funds precludes making grants for the construction of additional facilities for heart research.

Activity 1 (*b*): Grants for detection, diagnosis, and other control services: $375,000. Since these control grants are allocated on a formula basis, all States and Territories will have to operate their heart-control programs at a reduced level.

Activity 2 (*a*): Research, $408,000, apportioned as follows:

1. A reduction of $92,700 in personal services. A delay in the opening of the clinical center has resulted in the postponement of the proposed staffing of the intramural research program, including those components which deal with clinical investigation. As a result of this delay, it is estimated that dollar requirements for staffing will not be as great in 1954 as originally anticipated.

2. Travel. A reduction of $4,100 will be effected through restriction of travel in 1954.

3. Reimbursement for Clinical Center activities. The reduction of $229,800 in the Heart Institute's proportionate share of reimbursement for Clinical Center services results from a change in the activation schedule of the Clinical Center.

4. Supplies and materials. A reduction of $21,000 in the requirements for supplies and materials is anticipated as a result of postponement of recruitment.

5. Equipment. A reduction of $60,000 in available funds for purchase of equipment will limit our ability to obtain certain scientific instruments.

6. Taxes and assessments, $400. A reduction in this item may be realized as a result of a curtailment in personal services as explained in No. 1.

Activity 2 (*b*) 1: Review and approval of grants: A reduction of $4,000 in personal services.

Activity 2 (*b*) 2: Technical assistance to States, $48,000, primarily in personal services (7 positions). The reduction in this activity will require a lower level of consultative assistance to States in the fields of medicine, nursing, medical-social health education, diet therapy and program records and statistics.

Activity 2 (*b*) 3: Administration, $7,000. The reduction requires decreases of $3,000 in personal services and $4,000 in reimbursement to the National Institutes of Health, resulting from reduced requirements in central administration for the operation of the Clinical Center.

Dental Health Activities

Amounts available for obligation

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	$1,650,000	.....	$2,700,000	.....	$1,740,000	.....	+$90,000	.....	−$960,000
APPLICATION OF FUNDS										
Activities										
1. Grants:										
(a) For research and training:	.....	221,000	.....	564,000	.....	221,000	.....	0	.....	−343,000
1. Research projects	.....	50,000	.....	50,000	.....	50,000	.....	0	.....	0
2. Research fellowships	.....	0	.....	500,000	.....	0	.....	0	.....	−500,000
3. Construction of research facilities	.....		.....		.....		.....		.....	
2. Direct operations:										
(a) Research	59	386,000	59	579,000	59	573,000	0	+187,000	0	−6,000
(b) Other direct operations:										
1. Review and approval of research and training grants	1	11,500	1	11,000	1	11,000	0	−500	0	0
2. Technical assistance to States	119	800,000	119	800,000	103	700,000	−16	−100,000	−16	−100,000
3. Coordination and development of dental resources	21	126,000	21	126,000	21	115,000	0	−11,000	0	−11,000
4. Administration	7	55,500	7	70,000	7	70,000	0	+14,500	0	0
Total obligations	207	1,650,000	207	2,700,000	191	1,740,000	−16	+90,000	−16	−960,000

EXPLANATION OF CHANGE

The reduction of $960,000 is distributed as follows:

Activity 1 (*a*) 1: Grants for research projects, $343,000. This reduction will sharply reduce dental research in universities and other institutions. Fields of research affected will be pyorrhea, harelip, cleft palate, and other dental diseases. Of the $221,000 available under this project $149,000 will be required for continuation of grants now under way. The number of new grants to be supported will be reduced from 56 to 10.

Activity 1 (*a*) 3: Grants for construction of research facilities, $500,000. This activity has been eliminated.

Activity 2 (*a*): Research: This overall reduction of $6,000 will curtail the planned opportunities for visiting scientists to work for short terms in our clinic and laboratories, and will reduce official travel of scientific personnel.

Activity 2 (*b*) 2: Technical assistance to States, $100,000. Personal services (16 positions), $70,600; travel, $9,400; equipment, $20,000. The decrease will reduce substantially the provision of technical assistance to States for their establishment and maintenance of local dental programs.

Activity 2 (*b*) 3: Coordination and development of dental resources, $11,000. Personal services, $10,000; travel, $1,000. This reduction involves the abandonment of the proposed X-ray studies and will delay completion of the studies concerned with the improvement in efficiency of dental treatment methods.

Arthritis and Metabolic Disease Activities

Amounts available for obligation

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		0		$8,450,000		$4,976,000		+$4,976,000		−$3,474,000
Addition:										
1. Comparative transfer from: "Operating expenses, National Institutes of Health, Public Health Service"		[1] $4,568,900		0		0		−4,568,900		0
Total obligations		4,568,900		8,450,000		4,976,000		+407,100		−3,474,000
APPLICATION OF FUNDS										
Activities										
1. Grants for research and training:										
(a) Research projects		1,345,000		2,614,000		1,466,000		+121,000		−1,148,000
(b) Research fellowships		150,000		135,000		135,000		−15,000		0
(c) Training stipends		50,000		150,000		50,000		0		−100,000
(d) Construction of research facilities		0		2,000,000		0		0		−2,000,000
2. Direct operations:										
(a) Research	343	2,874,000	343	3,346,000	335	3,120,000	−8	+246,000	−8	−226,000
(b) Other direct operations:										
(1) Review and approval of research and training grants	1	17,500	1	18,000	1	18,000	0	+500	0	0
(2) Administration	10	132,400	10	187,000	10	187,000	0	+54,600	0	0
Total obligations	354	4,568,900	354	8,450,000	346	4,976,000	−8	+407,100	−8	−3,474,000

[1] $4,626,700 comparative transfer as shown in budget less $57,800 adjustment for reimbursements from other accounts included in such transfer.

EXPLANATION OF CHANGE

The reduction of $3,474,000 is distributed as follows:

Activity 1 (*a*): Grants for research projects, $1,148,000. Instead of being able to support approximately 104 new research project grants, only 12 such grants may be supported during the fiscal year. These 12 will be selected from an estimated total of 300 requests for support of research studies in arthritis, rheumatism, and metabolic diseases.

Activity 1 (*c*): Training stipends, $100,000. Because of the reduction no additional traineeships may be awarded (28 additional traineeships were planned in the original budget).

Activity 1 (*d*): Grants for construction of research facilities, $2,000,000. The proposal for a program of construction grants is omitted in the revised estimate.

Activity 2 (*a*): Research, $226,000; personal services (8 positions), $49,312; travel, $3,200; reimbursement to "Operating expenses, National Institutes of Health," $167,400; supplies and materials, $6,012; other, $76. The reduction will mean some curtailment of laboratory research, a delay in initiation of clinical studies on liver diseases, and a reduction in supporting research and patient-care services provided centrally through reimbursement to the National Institutes of Health appropriation.

Microbiology Activities

Amounts available for obligation

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	0	.....	$7,000,000	.....	$5,738,000	.....	+$5,738,000	.....	−$1,262,000
Addition:										
1. Comparative transfer from: "Operating expenses, National Institutes of Health, Public Health Service"	.....	[1] $5,479,200	.....	0	.....	0	.....	−5,479,200	.....	0
Total obligations	.....	5,479,200	.....	7,000,000	.....	5,738,000	.....	+258,800	.....	−1,262,000
APPLICATION OF FUNDS										
Activities										
1. Grants for research and training:										
(a) Research projects	.....	1,950,000	.....	2,947,000	.....	1,950,000	.....	0	.....	−997,000
(b) Research fellowships	.....	150,000	.....	117,000	.....	117,000	.....	−33,000	.....	0
2. Direct operations:										
(a) Research	450	3,221,350	478	3,718,000	469	3,453,000	+19	+231,650	−9	−265,000
(b) Other direct operations:										
(1) Review and approval of research and training grants	2	14,550	2	15,000	2	15,000	0	+450	0	0
(2) Administration	10	143,300	10	203,000	10	203,000	0	+59,700	0	0
Total obligations	462	5,479,200	490	7,000,000	481	5,738,000	+19	+258,800	−9	−1,262,000

[1] $5,650,200 comparative transfer as shown in budget less $171,000 adjustment for reimbursements from other accounts included in such transfer.

EXPLANATION OF CHANGE

The reduction of $1,262,000 is distributed as follows:

Activity 1 (*a*): Grants for research projects; $997,000. This reduction will permit the continuation in 1954 of microbiology research that is currently being supported by the Public Health Service, and in which carefully evaluated investments have already been made by the Federal Government. Through normal attrition due to termination of projects that will receive their last year of support in 1953, an estimated $400,000 will be available in 1954 for new projects in the sectional research program area.

Activity 2 (*a*): Research: $265,000; personal services (9 positions), $32,887; travel, $6,200; reimbursement to "Operating expenses, National Institutes of Health," $206,000; supplies and materials, $19,829; taxes and assessments, $84. The reduction will result in the closing of 1 field station and a 33 percent reduction in another field station doing research on dysentery in newborn infants and amebiasis. A sharp reduction is also reflected in auxiliary research services provided centrally (laboratory, technical and patient care services) due primarily to changes in clinical center activation and operation.

Neurology and Blindness Activities

Amounts available for obligation

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		0		$7,670,000		$2,574,000		+$2,574,000		−$5,096,000
Net transfers (see p. 179)		$1,972,300		0		0		−1,972,300		0
Total obligations		1,972,300		7,670,000		2,574,000		+601,700		−5,096,000
APPLICATION OF FUNDS										
Activities										
1. Grants for research and training:										
(a) Research projects		1,326,000		4,328,000		1,476,000		+150,000		−2,852,000
(b) Research fellowships		150,000		150,000		150,000		0		0
(c) Training grants		58,500		210,000		58,500		0		−151,500
(d) Training stipends		51,500		100,000		51,500		0		−48,500
(e) Construction of research facilities		0		2,000,000		0		0		−2,000,000
2. Direct operations:										
(a) Research	30	294,500	60	797,000	58	753,000	+28	+458,500	−2	−44,000
(b) Other direct operations:										
(1) Review and approval of research and training grants	2	22,000	2	22,000	2	22,000	0	0	0	0
(2) Administration	4	69,800	4	63,000	4	63,000	0	−6,800	0	0
Total obligations	36	1,972,300	66	7,670,000	64	2,574,000	+28	+601,700	−2	−5,096,000

EXPLANATION OF CHANGE

The reduction of $5,096,000 is distributed as follows:

Activity 1 (*a*). Grants for research projects: Reduction of $2,852,000. To provide continued support without loss of investment for projects approved in prior years requires $1,060,000. The amount in the revised estimate would reduce from 317 to 40 the number of new projects to be supported in 1954.

Activity 1 (*c*). Training grants: Reduction of $151,500. The reduction in funds will reduce from 15 to 6 the number of grants to medical schools for training teachers in the specialized fields of neurologic and ophthalmic research.

Activity 1 (*d*). Training stipends: Reduction of $48,500. This reduction eliminates a proposal to increase by 20 the number of training stipend awards to provide specialized training to professional persons in the diagnosis, treatment, and rehabilitation of patients afflicted with neurologic or ophthalmic diseases.

Activity 1 (*e*). Grants for construction of research facilities: Reduction of $2,000,000. This would eliminate a proposed new program to improve and expand facilities for research in neurologic and blinding eye diseases.

Activity 2 (*a*). Research: Reduction of $44,000. Personal services (2 positions), $9,400; travel, $1,500; reimbursement to "Operating expenses, National Institutes of Health," $32,000; other, $1,100. The reduction is due primarily to delay in clinical center opening and attendant reduced clinical operating levels in 1954. Two positions are dropped in research on special senses and there will be recruitment delays in clinical research.

Construction of Research Facilities (Liquidation of Contract Authorization)

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	-------	$3,230,000	-------	$3,000,000	-------	$2,500,000	-------	−$730,000	-------	−$500,000
APPLICATION OF FUNDS										
Activity										
1. Liquidation of contract authorization	-------	3,230,000	-------	3,000,000	-------	2,500,000	-------	−730,000	-------	−500,000

Revision of 1954 estimate

Original estimate	$3,000,000
Revised estimate	2,500,000
Net change	−500,000

EXPLANATION OF CHANGE

A review of requirements for funds necessary to permit liquidation of obligations incurred under escalation authority indicates that expenditures for 1954 will be $500,000 below the amount originally determined to be necessary for expenditure during such period.

Retired Pay of Commissioned Officers

Amounts available for obligation

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		$1,186,000		$1,215,000		$1,197,000		+$11,000		−$18,000
Addition:										
1. Prior year balance available		0		+53,000		+71,000		+71,000		+18,000
Deduction:										
1. Balance available in subsequent year		−53,000		0		0		+53,000		0
Total obligations		1,133,000		1,268,000		1,268,000		+135,000		0
APPLICATION OF FUNDS										
Activity										
1. Retired pay of commissioned officers		1,133,000		1,268,000		1,268,000		+135,000		0
Total obligations		1,133,000		1,268,000		1,268,000		+135,000		0

Revision of 1954 estimate

Original estimate	$1,215,000
Revised estimate	1,197,000
Net change	−18,000

EXPLANATION OF CHANGE

This reduction is made possible by a corresponding increase in the amount of funds estimated to be available in 1954 from the 1953 appropriation.

Salaries and Expenses, Public Health Service

Amounts available for obligation

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	$3,170,250	.....	$3,138,000	.....	$3,100,000	.....	−$70,250	.....	−$38,000
Net transfers	.....	−32,300	.....	0	.....	0	.....	+32,300	.....	0
Total direct obligations	.....	3,137,950	.....	3,138,000	.....	3,100,000	.....	−37,950	.....	−38,000
APPLICATION OF FUNDS										
Activities										
1. Public health methods and reports	80	528,000	80	528,000	78	516,000	−2	−12,000	−2	−12,000
2. International health activities	25	137,000	25	137,000	23	127,000	−2	−10,000	−2	−10,000
3. Management and central services	469	2,472,950	465	2,473,000	465	2,457,000	−4	−15,950	0	−16,000
Total direct obligations	574	3,137,950	570	3,138,000	566	3,100,000	−8	−37,950	−4	−38,000

Revisions of 1954 estimate

Original estimate	$3,138,000
Revised estimate	3,100,000
Net change	−38,000

EXPLANATION OF CHANGE

The reduction of $38,000 is distributed as follows:

Activity 1: Public health methods and reports: Personal services (2 positions), $7,500; travel, $2,000; printing and reproduction, $2,500.

Activity 2: International health activities: Personal services (2 positions), $10,000.

Activity 3: Management and central services: Travel, $6,000; communication services, $2,800; printing and reproduction, $2,800; other contractual services, $1,500; equipment, $2,900.

NOTE.—The revised budget makes no change in the amount of $200,000 requested for the "Service and supply fund."

St. Elizabeths Hospital

Salaries and Expenses

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	2,607	$2,520,000	2,607	$2,428,500	2,607	$2,417,000		−$103,000		−$11,500
Additions:										
1. Reimbursements		10,276,210		10,407,644		10,365,677		+89,467		−41,967
Decreases:										
1. Comparative transfer to "Salaries and expenses, Office of the General Counsel, Office of the Administrator, Federal Security Agency"		−3,520						+3,520		
Total obligations		12,792,690		12,836,144		12,782,677		−10,013		−53,467
APPLICATION OF FUNDS										
Activities										
1. Operation and maintenance of hospital	2,565	12,406,688	2,565	12,425,507	2,565	12,372,040		−34,648		−53,467
2. Operation of farm	15	71,863	15	69,863	15	69,863		−2,000		
3. Operation of cafeteria	15	79,757	15	79,362	15	79,362		−395		
4. Training program	12	234,382	12	261,412	12	261,412		+27,030		
Total obligations	2,607	12,792,690	2,607	12,836,144	2,607	12,782,677		−10,013		−53,467

NOTE.—Based on anticipated reductions in food, medicine and medical supplies costs, the $53,467 reduction shown in the revised estimate is distributed as follows: Food, $50,447; medicine and medical supplies, $3,020.

Reimbursement detail

	Estimate, 1953	Revised estimate, 1954	Change
Reimbursements for services performed (patient care):			
Veterans' Administration	$625,975.00	$625,975.00	
U. S. Soldiers' Home	39,346.00	39,346.00	
Bureau of Indian Affairs	137,714.00	137,714.00	
Subtotal	803,035.00	803,035.00	
Payments received from non-Federal sources:			
District of Columbia (patient care)	9,389,625.00	9,479,052.00	+$89,427
Officers' board	15,850.00	15,850.00	
Cafeteria sales	49,000.00	49,000.00	
Sale of scrap	15,130.00	15,170.00	+40
Other miscellaneous	3,570.00	3,570.00	
Subtotal	9,473,175.00	9,562,642.00	+89,467
Total reimbursements	10,276,210.00	10,365,677.00	+89,467
Reimbursement rate (per day)	4.90	4.90	

Major Repairs and Preservation of Buildings and Grounds

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		(1)		$451,500		$399,500				−$52,000
Rewiring of patients' building				76,000		76,000				
Earth stabilization and erosion protection				176,000		176,000				
Remodeling of creamery				52,000						
Repair and conversion of steam boiler				60,000		60,000				−52,000
Replacement of elevators				87,500		87,500				
Total				451,500		399,500				−52,000

NOTE.—This reduction is being accomplished by the deferment of the creamery remodeling project. The revised budget makes no change in the request for $195,000 for "Construction, maximum security building."

[1] Excludes $136,500 appropriated in 1953 for rewiring of patients' buildings ($75,000) and repair and conversion of steam boiler ($61,500).

SOCIAL SECURITY ADMINISTRATION

Salaries and Expenses, Children's Bureau

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	$1,550,000	.....	$1,585,000	.....	$1,550,000	.....	.....	.....	−$35,000
Additions	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Deductions	.....	.....	.....	.....	.....	.....	.....	.....	.....	−35,000
Total obligations	.....	1,550,000	.....	1,585,000	.....	1,550,000	.....	.....	.....	.....
Activities										
1. Development of State and local health services for children	79.5	552,883	82.5	572,387	79.5	552,883	.....	.....	−3	−19,504
2. Development of State and local social services for children	46.5	313,588	46.5	313,588	46.5	313,588	.....	.....	.....	.....
3. Research in childlife and services for children	41	230,074	44	245,570	41	230,074	.....	.....	−3	−15,496
4. Dissemination of information for parents and others working with children	29	261,638	29	261,638	29	261,638	.....	.....	.....	.....
5. Administration	38	191,817	38	191,817	38	191,817	.....	.....	.....	.....
Total obligations	234	1,550,000	240	1,585,000	234	1,550,000	.....	.....	−6	−35,000

NOTE.—The $35,000 reduction is allocated as follows:
Activity 1. Personal services (3 positions), $16,554; travel, $2,880; taxes and assessments, $70; total, $19,504.
Activity 3. Personal services (3 positions), $13,826; travel, $1,350; communication services, $40; employee health program, $27; supplies and materials, $105; taxes and assessments, $148; total, $15,496.

Grants to States for Maternal and Child Welfare

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate		$28,600,000		$32,600,000		$30,600,000		+$2,000,000		−$2,000,000
Additions										
Deductions										
Total obligations		28,600,000		32,600,000		30,600,000		+2,000,000		−2,000,000
Application of Funds										
Activities										
1. Maternal and child health services		12,746,579		13,313,158		12,517,976		−228,603		−795,182
2. Crippled children's services		11,482,498		11,950,028		11,227,138		−255,360		−722,890
3. Child welfare services		4,370,923		7,336,814		6,854,886		+2,483,963		−481,928
Total obligations		28,600,000		32,600,000		30,600,000		+2,000,000		−2,000,000

The $2 million reduction in the original 1954 estimate is applied to the 3 programs as indicated above. Language contained in the 1953 appropriation act, and proposed for continuance in the 1954 appropriation act, provides that Federal Treasury carryover balances from allotments of prior years be added to the amount appropriated for the fiscal year and the total thus obtained apportioned over the 3 programs, each program receiving the same percentage of the total as of the total authorized for appropriation each fiscal year by title V of the Social Security Act. The revised 1954 estimate of $30,600,000, together with the estimated carryover balances from 1952 allotments of $1,157,713 (pp. 73; 81, 89–95 revised), will make available for apportionment to the States $31,757,713. This is to be compared with a total available in 1953 of $33,880,071 ($28,600,000 appropriated and $5,280,071 carried over from prior years).

Language in the 1953 appropriation act eliminates, in effect, the 2-year carryover provisions of title V of the Social Security Act beginning with allotments made for the fiscal year 1953.

Salaries and Expenses, Office of the Commissioners

Item	1953 appropriation (estimate)		Original 1954 estimate		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	$185,000	.....	$190,000	.....	$173,000	.....	−$12,000	.....	−$17,000
Additions:										
1. Reimbursement from OASI trust fund	.....	109,000	.....	135,000	.....	123,500	.....	+14,500	.....	−11,500
Total obligations	.....	294,000	.....	325,000	.....	296,500	.....	+2,500	.....	−28,500
APPLICATION OF FUNDS										
Activity										
1. Direction and coordination of the social security program	22	154,128	24	163,286	22	155,428	.....	+1,300	−2	−7,858
2. Appraisal and development of the social security program	21	139,872	26	161,714	21	141,072	.....	+1,200	−5	−20,642
Total obligations	43	294,000	50	325,000	43	296,500	.....	+2,500	−7	−28,500

The $28,500 reduction is allocated as follows:

Activity 1:	$7,753
Personal services (2 positions)	45
Supplies and materials	60
Equipment	7,858
Activity 2:	20,247
Personal services (5 positions)	115
Supplies and materials	280
Equipment	20,642
Total	28,500

Note.—The revised budget contained no change in the request under the following Social Security Administration appropriations: "Salaries and expenses, Bureau of Old-Age and Survivors Insurance (trust fund)"; "Construction of building, Bureau of Old-Age and Survivors Insurance (trust fund)"; "Grants to States for public assistance"; "Salaries and expenses, Bureau of Public Assistance"; "Operating fund, Federal credit unions."

OFFICE OF THE SECRETARY

SALARIES AND EXPENSES, OFFICE OF THE SECRETARY

Item	1953 appropriation (estimate) [1]		Original 1954 estimate [1]		Revised 1954 estimate		Revision compared with—			
							1953 appropriation (estimate)		Original 1954 estimate	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
Total appropriation or estimate	.....	$950,000	.....	$1,120,000	.....	$1,226,000	.....	+$276,000	.....	+$106,000
Additional amounts available for obligation	.....	293,329	.....	184,329	.....	204,329	.....	−89,000	.....	+20,000
Total obligations	.....	1,243,329	.....	1,304,329	.....	1,430,329	.....	+187,000	.....	+126,000
APPLICATION OF FUNDS										
Activities										
1. Executive direction (and program coordination)	14	107,980	14	107,980	45	342,045	+31	234,065	+31	234,065
2. Program coordination and development	20	140,825	25	165,125	.....	.....	−20	−140,825	−25	−165,125
3. Publications and reports	10	63,430	10	63,430	10	63,430	.....	.....	.....	.....
4. Administrative services	66	373,686	73	409,386	79	455,291	+13	81,605	+6	45,905
5. General services	117	557,408	117	558,408	117	569,563	.....	12,155	.....	11,155
Total obligations	227	1,243,329	239	1,304,329	251	1,430,329	+24	187,000	+12	126,000

[1] Funds shown in 1953 and original 1954 estimate are the submissions to the Congress for the Federal Security Agency prior to creation of Department of Health, Education, and Welfare.

EXPLANATION OF INCREASE OVER ORIGINAL 1954 ESTIMATES

Activity 1. The increase of 31 positions and $234,065 are distributed as follows:

	Number of positions	Amount of increase			
		Salaries	W. a. e.	Travel	Total
Transferred from activity 2, program coordination and development:					
Federal-State Coordinator and Secretary	2	$94,982	$2,500	$6,000	$103,482
Office of International Relations	4				
Committee on Aging and Geriatics	7				
Assistant to (Administrator) Secretary and stenographer	2				
Total	15				
New positions for immediate Office of Secretary (including 1 Secretary for Federal-State Coordinator included in original 1954 estimate)	16	130,960		3,730	134,690
New positions for Security Office (including 2 secretarial)	4	24,545		1,000	25,545
W. a. e. employees: Pay in excess of 52-week base and other salary adjustments		882	3,500		4,382
Total	35	251,369	6,000	10,730	268,099
Less 4 positions available in 1953 which are abolished in 1954 $41,534, salaries of 4 positions deleted offset by increased salaries of $7,500 for Secretary and Undersecretary	−4	−34,034			−34,034
Net increase	+31	217,335	6,000	10,730	234,065

Activity 2. The decrease of 25 positions and $165,125 is explained below:

	Number	Salaries	W. A. E.	Travel	Total
Presently available (1953) positions:					
(a) Transferred to activity "Executive direction and program coordination"	[1] 15	$94,982	$2,500	$6,000	$103,482
(b) Abolished	5	36,043		1,300	37,343
Additional positions requested in original 1954 estimate:					
(a) Transferred to activity "Executive direction and program coordination" (1 stenographer for Federal-State coordinator)	1	3,175			3,175
(b) 4 newly requested program positions deleted	4	20,125		1,000	21,125
Total	−25	154,325	2,500	8,300	165,125

[1] See breakdown under activity 1.

Activity 4. Increase over original 1954 estimate is 6 positions and $45,905:

	Number of positions	Amount
Director of Administration and secretary	2	$20,360
Planning and statistics staff (including $1,000 travel)	4	25,545
Total	6	45,905

Activity 5. No new positions requested. $11,155 is required to pay for 50 security investigations, at approximately $225 each.

NOTE.—The revised budget contained no change in the amount requested under the following appropriations for the Office of the Secretary: "Salaries and expenses, Office of Field Services"; "Salaries and expenses, Office of the General Counsel"; "Surplus property disposal."

APPENDIX B

DISTRIBUTION OF 1954 ANNUAL APPROPRIATION ESTIMATES

Summary by constituent organizations

Organization	Grand total estimate	Grants and benefits	Operation of educational institutions	Operation of hospitals and patient services	Planning and construction	Program operation	Administration
American Printing House for the Blind	$175,000	$175,000					
Columbia Institution for the Deaf	451,000		$410,000		$41,000		
Food and Drug Administration	5,648,000					$5,338,150	$309,850
Freedmen's Hospital	3,104,000		2,535,000	$3,104,000			
Howard University	3,335,000				800,000		
Office of Education	85,976,370	83,050,370				2,652,468	273,532
Office of Vocational Rehabilitation	23,690,000	22,805,000				785,077	99,923
Public Health Service	219,665,000	139,073,000		32,918,500	2,500,000	43,176,900	1,996,600
St. Elizabeths Hospital	3,011,500			2,816,500	195,000		
Social Security Administration	1,374,223,000	1,370,600,000				3,077,071	545,929
Office of the Secretary	3,866,000					2,942,300	923,700
Total, Department of Health, Education, and Welfare	1,723,144,870	1,615,703,370	2,945,000	38,839,000	3,536,000	57,971,966	4,149,534
Percent distribution	100.0	93.8	0.2	2.2	0.2	3.4	0.2

Salaries and expenses, Office of the Secretary

	Summary of revised 1954 increase over–			
	1953		1954 original estimate	
	Positions	Amount	Positions	Amount
New positions for immediate Office of Secretary	16	$134,690	15	$131,515
Increased salaries for Secretary, and Under Secretary		+7,500		+7,500
Less positions abolished:				
(*a*) Executive direction	−4	−41,534	−4	−41,534
(*b*) Program coordination and development	−5	−37,343	−9	−58,468
Net increase for immediate Office of Secretary	7	63,313	2	39,013
New positions for Security Office	4	25,545	4	25,545
Consultant services, $3,500, and pay in excess of 52-week base, etc., $882		4,382		4,382
Net increase, executive direction and program coordination	11	93,240	6	68,940
Office of Administration	3	24,020	2	20,360
Organization and methods	2	9,715		
Budget and finance	4	22,325		
Planning and statistics staff	4	25,545	4	25,545
Net increase, administrative services	13	81,605	6	45,905
Security investigations		11,155		11,155
Miscellaneous expenses (other than travel which is included in above figures)		1,000		
Net increase, General Services		12,155		11,155
Total increase	24	187,000	12	126,000

Distribution of 1954 annual appropriation estimates

Organization and appropriation	Grand total estimate	Grants and benefits		Operation of educational institutions	Operation of hospitals and patient services	Planning and construction	Program operation	Administration	Remarks
		Amount	Type						
American Printing House for the Blind	$175,000	$175,000	Nonmatching grant-in-kind						
Columbia Institution for the Deaf	451,000			$410,000		$41,000			20 U. S. C. 101, ch. 20; Public Law 354, 82d Cong.
Food and Drug Administration:									
Salaries and expenses	5,648,000						$5,338,150	$309,850	31 D. C. Code 1001–1007; Public Law 362, 81st Cong.
Certification and inspection services.[1]									15 U. S. C. 401–411; 21 U. S. C. 24, 26, 41–50, 61–64, 141–149, 301, 331, 352–5½, 392.
Freedmen's Hospital:									
Salaries and expenses	3,104,000				$3,104,000				32 D. C. Code 317–320.
Facilities planning									
Total, Freedmen's Hospital	3,104,000				3,104,000				
Howard University:									
Salaries and expenses	2,535,000			2,535,000					
Plans and specifications	30,000					30,000			20 U. S. C. 123,
Construction of buildings, appropriation	170,000					170,000			
Liquidation cash	600,000					600,000			
Total, Howard University	3,335,000			2,535,000		800,000			
Office of Education:									
Promotion and further development of vocational education	14,048,870	14,048,870	100 percent matching						
Further endowment of colleges of agriculture	2,501,500	2,501,500	Nonmatching						20 U. S. C. 15h, 29, 30; Public Law 462, 81st Cong.
Salaries and expenses	2,926,000								7 U. S. C. 329.
Payments to school districts	66,500,000	66,500,000	Nonmatching				2,652,468	273,532	20 U. S. C. Chs. 1, 2, and 6–A; Public Law 550, 82d Cong. Public Law 874, 81st Cong.
Total, Office of Education	85,976,370	83,050,370					2,652,468	273,532	

Office of Vocational Rehabilitation:									
Payments to States	23,000,000	22,805,000	Vocational guidance and administration, 100 percent; other services, 50 percent.				195,000		29 U. S. C., ch. 4.
Salaries and expenses	690,000						590,077	99,923	29 U. S. C., ch. 4; 20 U. S. C., ch. 6–A.
Total, Office of Vocational Rehabilitation.	23,690,000	22,805,000					785,077	99,923	
Public Health Service:									
Control of venereal diseases	6,695,000	5,195,000	Administrative requirements are 50 percent matching on formula control grants. Funds for rapid treatment center operations and special case-finding projects are also included.				1,470,100	29,900	42 U. S. C. 246 (a), 266.
Control of tuberculosis	5,725,000	4,000,000	100 percent matching requirement.				1,696,600	28,400	42 U. S. C. 246 (b).
Assistance to States, general	16,215,000	13,000,000	50 percent matching requirement.				3,207,800	7,200	42 U. S. C. 241, 243, 244, 245 and 246 (c).
Control of communicable diseases.	5,335,000						5,321,600	13,400	42 U. S. C. 241, 243, 264 and sec. 704 of the act of July 1, 1944, Public Law 410.
Engineering, sanitation and industrial hygiene.	3,850,000						3,821,000	29,000	42 U. S. C. 241, 243, 264 and 33 U. S. C. 466–466 (j).
Grants, water pollution control			No matching requirement						33 U. S. C. 466–466 (j).
Disease and sanitation investigations and control, Territory of Alaska.	1,082,000	540,000	do				542,000		42 U. S. C. 241, 243, 246, 264, 266, and sec. 704 of the act of July 1, 1944, Public Law 410.
Grants for hospital construction:									
Obligational cash	60,000,000	60,000,000	Graduated matching requirement.						42 U. S. C. 291–291 (m).
Liquidating cash	19,700,000	19,700,000							
Salaries and expenses, hospital construction service.	1,125,000						1,088,500	36,500	42 U. S. C. 291–291 (m).
Hospitals and medical care	33,551,000	500,000	No matching requirement		32,918,500		90,000	42,500	42 U. S. C. 220, 222, 248, 249, 251, 253, 255, 256, 257, 259, 260, sec. 710 of the act of July 1, 1944, Public Law 410 and 5 U. S. C. 150, Public Law 411, 82d Cong.
Foreign quarantine service	3,050,000						3,036,800	13,200	42 U. S. C. 249, 252, 264–272.
Operating expenses, National Institutes of Health.	4,675,000	4,124,000	Research grants. No matching requirement.				551,000		42 U. S. C. 241.
Salaries and expenses and grants, National Cancer Institute.	15,780,000	10,323,000	50 percent matching requirement for grants to States, $2,250,000; research and training grants no matching $8,073,000.				5,443,000	14,000	42 U. S. C. 241, 281–286.

[1] Provided for entirely on fee basis, $1,050,000 estimated for 1954.

Distribution of 1954 annual appropriation estimates—Continued

Organization and appropriation	Grand total estimate	Grants and benefits		Operation of educational institutions	Operation of hospitals and patient services	Planning and construction	Program operation	Administration	Remarks
		Amount	Type						
Public Health Service—Continued									
Mental health activities	$9,817,000	$7,212,000	50 percent matching requirement for grants to States, $2,325,000; research and training grants no matching $4,887,000.				$2,594,500	$10,500	42 U. S. C. 241, 242, 242 (a), 243, 244, 246 (c).
Salaries and expenses and grants, National Heart Institute.	11,040,000	7,557,000	50 percent matching requirement for grants to States, $1,125,000; research and training grants no matching, $6,432,000.				3,472,000	11,000	42 U. S. C. 241, 285, 287–287 (d).
Dental health activities	1,740,000	271,000	No matching requirement				1,461,500	7,500	42 U. S. C. 241, 243, 246 (c), 285, 288–288 (e).
Arthritis and metabolic diseases	4,976,000	1,651,000	do				3,315,700	9,300	42 U. S. C. 241, 289–289 (c).
Microbiology activities	5,738,000	2,067,000	do				3,663,100	7,900	42 U. S. C. 241, 262, 263, 289–289 (c).
Neurology and blindness activities.	2,574,000	1,736,000	do				831,200	6,800	42 U. S. C. 241, 289–289 (c).
Construction of research facilities: Liquidating cash.	2,500,000					$2,500,000			42 U. S. C. 248, 60 Stat. 421.
Retired pay of commissioned officers.	1,197,000	1,197,000							42 U. S. C. ch. 6-A.
Salaries and expenses	3,100,000						1,370,500	1,729,500	42 U. S. C. ch. 6-A.
Service and supply fund	200,000						200,000		
Total, Public Health Service.	219,665,000	139,073,000			$32,918,500	2,500,000	43,176,900	1,996,600	
Percent distribution	100.0	63.3			15.0	1.1	19.7	0.9	
St. Elizabeths Hospital:									
Salaries and expenses	2,417,000				2,417,000				24 U. S. C. ch. 4.
Major repairs and preservation of buildings and grounds.	399,500				399,500				24 U. S. C. ch. 4.
Construction, Maximum Security Building.	195,000					195,000			24 U. S. C. ch. 4.
Total, St. Elizabeths Hospital	3,011,500				2,816,500	195,000			

Social Security Administration: Bureau of Federal Credit Unions: Operating fund.[1]	250,000						250,000		12 U. S. C. 1751–1772; act of June 29, 1948, Public Law 813, 80th Cong., Public Law 322, 82d Cong.
Bureau of Public Assistance: Grants	1,340,000,000	1,340,000,000	Matching under titles I, IV, X, and XIV of Social Security Act, as amended.						42 U. S. C. ch. 7, subchs. I, IV, and X, and XIV, secs. 7 and 8, Public Law 590, 82d Cong.
Salaries and expenses	1,650,000						1,468,888	181,112	42 U. S. C. ch. 7, subchs. I, IV, X and XIV, and sec. 903.
Children's Bureau: Salaries and expenses	1,550,000						1,358,183	191,817	42 U. S. C. ch. 7, subch. V; 42 U. S. C. ch. 6.
Grants to States, maternal and child welfare.	30,600,000	30,600,000	50 percent matching, 50 percent nonmatching, for maternal and child health service and services for crippled children. Nonmatching for child welfare services, title V of Social Security Act, as amended.					173,000	42 U. S. C. ch. 7, subch. V; title II Public Law 452, 82d Cong. 42 U. S. C. 901–904.
Office of Commissioner: Salaries and expenses [2]	173,000						3,077,071	545,929	
Total, Social Security Administration.	1,374,223,000	1,370,600,000					468,600	757,400	
Office of the Secretary:[2] Salaries and expenses, Office of the Secretary.	1,226,000						1,791,000	139,000	5 U. S. C. 133, Reorganization Plan No. 2, 1946.
Salaries and expenses, Office of Field Services.	1,930,000						427,700	27,300	
Salaries and expenses, Office of the General Counsel.	455,000						255,000		Public Law 152, 81st Cong., sec. 4 Public Law 754, 81st Cong.
Surplus Property Disposal	255,000								
Total, Office of the Secretary	3,866,000						2,942,300	923,700	
Total, Department of Health, Education and Welfare.	1,723,144,870	1,615,703,370		2,945,000	38,839,000	3,536,000	57,971,966	4,149,534	
Percent distribution	100.0	93.8		0.2	2.2	0.2	3.4	0.2	

[1] Interest-bearing loan to provide working capital. The Bureau otherwise is operated entirely out of fees received.
[2] Excludes transfers from OASI trust fund and the Food and Drug Administration.

APPENDIX C

Revised Tables

The following are revisions of tables which were presented to the committee during the hearings on the original budget of the Public Health Service. The revisions in 1954 statistics were made necessary by the revisions subsequently made in the budget for the Public Health Service. The page on which the unrevised table appears is indicated in parentheses immediately preceding each of the following revised tables.

GENERAL, PUBLIC HEALTH SERVICE

(P. 588)

Public Health Service appropriations, 1945 to 1953, inclusive, and revised budget 1954

[In thousands of dollars]

	Medical research grants	Nonresearch grants, excluding hospitals	Hospital construction grants	Research construction grants	Public Health Service capital outlay	Direct medical care	Technical services	Law enforcement	Direct research	Other	Total
1945	123	84,383	0	0	0	17,370	17,306	1,534	2,360	4,648	127,724
1946	1,040	89,039	0	0	0	20,184	20,192	1,901	2,778	7,170	142,304
1947	3,711	54,052	0	0	0	20,597	12,559	2,108	4,425	8,070	105,515
1948	11,420	45,681	75,000	2,303	2,650	22,678	12,994	2,589	7,584	9,948	192,847
1949	14,871	44,035	75,000	8,000	30,630	26,752	18,412	3,336	10,961	7,452	239,449
1950	17,582	52,961	150,000	12,059	16,900	78,360	18,792	3,308	13,018	8,381	321,361
1951	18,922	44,161	85,000	0	8,175	29,024	19,061	3,214	13,810	7,502	228,869
1952	20,840	44,837	82,500	0	7,035	31,546	18,959	3,274	14,774	7,577	231,342
1953	23,209	43,298	75,000	0	300	33,188	18,396	3,294	17,639	7,283	221,607
1954	22,957	35,219	60,000	0	0	32,961	16,312	3,279	19,366	7,371	197,465

NOTE.—Statement includes contract authorizations but excludes amounts appropriated to liquidate contract authorizations.

HOSPITALS AND MEDICAL CARE

(P. 907)

Average daily patient load by beneficiary group

	Actual, 1952	Estimate, 1953	Estimate, 1954
All beneficiaries	6,957	6,510	6,061
Nonreimbursable	5,373	5,496	5,428
Seamen (American and Government)	2,661	2,706	2,650
Narcotic addicts	1,435	1,500	1,515
Patients with leprosy	[1] 409	[1] 412	412
Coast Guard	371	402	405
Bureau of Employees' Compensation	302	302	287
Other	195	174	159
Reimbursable	1,584	1,014	633
Veterans	1,243	643	268
Foreign seamen	115	122	121
Armed Forces	70	74	72
Immigration	32	33	33
Dependents	99	112	110
Other	25	30	29

[1] Includes an average of 2 patients in general hospitals.

(P. 908)

Comparative statement of reimbursements for 1952, 1953, and 1954

	Actual, 1952	Estimate, 1953	Estimate, 1954	Revised estimate, 1954
Veterans	$5,561,169	$2,742,811	$2,456,377	$841,252
Foreign seamen	536,647	634,553	651,434	651,434
Armed Forces	203,221	228,198	233,126	233,126
Immigration	155,184	171,641	171,605	171,605
Dependents	63,410	71,540	70,262	70,262
Other	94,062	115,998	117,512	117,512
Outpatient visits	30,183	30,339	26,764	26,889
Total, operation of hospitals	6,643,876	3,995,080	3,727,080	2,112,080
Total, operation of health units	308,588	330,420	330,820	330,820
Total, personnel detailed to other agencies	780,194	981,100	1,017,100	1,017,100
Receipts from trade-ins	4,104			
Total reimbursements	7,736,762	5,306,000	5,075,000	3,460,000

(P. 914)

Ration costs by type of hospital, including value of station-produced subsistence

Type of hospital	Type of rations	Number of rations	Average ration cost	Subsistence requirements
Fiscal year 1952 actual:				
General hospitals	Patients	1,477,015	$0.953	$1,407,595
Special hospitals	do	328,684	1.177	386,890
Neuropsychiatric hospitals	do	741,667	.819	607,176
All hospitals	Employees and guests	565,333	.953	538,586
Gross subsistence requirements		3,112,699	.945	2,940,247
Less:				
Farm produced				93,603
Supplies from decommissioned ships.				58,184
Net subsistence requirements				2,788,460
Fiscal year 1953 estimate:				
General hospitals	Patients	1,273,850	1.00	1,273,850
Special hospitals	do	332,150	1.15	382,000
Neuropsychiatric hospitals	do	770,150	.88	677,700
All hospitals	Employees and guests	498,225	1.00	498,225
Gross subsistence requirements		2,874,375	.985	2,831,775
Less estimated value of station-produced goods.				81,675
Net subsistence requirements				2,750,100
Fiscal year 1954 revised estimate:				
General hospitals	Patients	1,111,790	.97	1,078,440
Special hospitals	do	324,850	1.125	365,450
Neuropsychiatric hospitals	do	775,625	.854	662,600
All hospitals	Employees and guests	414,655	.97	402,210
Gross subsistence requirements		2,626,920	.955	2,508,700

FOREIGN QUARANTINE SERVICE

(P. 935)

5-year work trend of important factors

	1950	1951	1952	1953 estimate [1]	1954 estimate
Quarantine inspection:					
Vessels inspected	22,389	25,343	29,728	34,113	38,498
Persons on vessels inspected	1,518,345	1,509,045	1,875,531	2,242,017	2,608,503
Airplanes inspected	39,921	43,036	45,638	48,240	50,842
Persons on airplanes inspected	517,276	616,515	703,175	789,835	876,495
Mexican-border inspections	28,037,060	29,569,836	33,353,409	37,136,982	40,920,555
Persons treated	218,616	315,912	432,719	549,526	666,333
Immigration medical examination:					
Examination of aliens (United States ports and airports)	[2] 1,330,622	[2] 1,428,639	[2] 1,633,706	1,695,022	1,875,904
Medical certifications	[2] 53,135	[2] 50,622	[2] 50,257	25,908	25,919
Visa applicants examined (abroad)	89,229	81,206	112,928	144,650	176,372
Visa applicant medical notifications (abroad)	26,235	23,664	33,739	43,814	53,889
Personnel:					
Budgeted positions	650	623	603	603	603
Average employment	665	619	579	575	572

[1] Estimated on the basis of the increased workload in 1952 over 1951.
[2] Contain displaced persons arriving at United States ports and airports of entry.

NATIONAL INSTITUTES OF HEALTH

(P. 963)

Man-years involved in review and approval of research and training grants, revised 1954 budget

Activity	PHS full-time staff	Advisory councils	Study sections	Total man-years
National Institutes of Health	98.8	0.2	3.5	102.5
Cancer	13.2	2.0	----	15.2
Mental	14.0	1.8	1.0	16.8
Heart	12.0	3.0	----	15.0
Dental	1.0	1.0	----	2.0
Arthritis	1.0	.2	----	1.2
Microbiology	2.0	----	----	2.0
Neurology	1.8	.2	----	2.0
Total	143.8	8.4	4.5	156.7

(P. 964)

Total cost involved in review and approval of research and training grants revised 1954 budget

Activity	Direct			Study sections	Total cost
	PHS full-time staff	Advisory councils	Total direct		
National Institutes of Health	$543,000	$8,000	$551,000	$115,000	$666,000
Cancer	75,700	20,300	96,000	----	96,000
Mental	97,700	22,300	120,000	18,000	138,000
Heart	63,500	22,500	86,000	----	86,000
Dental	4,360	6,640	11,000	----	11,000
Arthritis	11,500	6,500	18,000	----	18,000
Microbiology	15,000	----	15,000	----	15,000
Neurology	14,300	7,700	22,000	----	22,000
Total	825,060	93,940	919,000	133,000	1,052,000

1954 BUDGET OF NATIONAL INSTITUTES BY FUNCTIONAL CATEGORY

(P. 976)

	Operating expenses, NIH	Arthritis	Microbiology	Neurology	Cancer	Mental	Heart	Dental	Total
Grants:									
Research projects	$4,000,000	$1,466,000	$1,950,000	$1,476,000	$4,734,000	$1,649,000	$4,927,000	$221,000	$20,423,000
Research fellowships	124,000	135,000	117,000	150,000	514,000	187,000	357,000	50,000	1,634,000
Teaching grants					1,625,000		1,023,000		2,648,000
Training grants				58,500		3,051,000			3,109,500
Training stipends		50,000		51,500	300,000		125,000		526,500
Grants to States					2,250,000	2,325,000	1,125,000		5,700,000
Special control grants					900,000				900,000
Total grants	4,124,000	1,651,000	2,067,000	1,736,000	10,323,000	7,212,000	7,557,000	271,000	34,941,000
Direct operations:									
Research		3,120,000	3,453,000	753,000	4,669,000	1,785,000	2,914,000	573,000	17,267,000
Review and approval of grants	551,000	18,000	15,000	22,000	96,000	120,000	86,000	11,000	919,000
Training activities						60,000			60,000
Technical assistance to States					353,000	361,000	297,000	700,000	1,711,000
Coordination and development of dental resources								115,000	115,000
Administration		187,000	203,000	63,000	339,000	279,000	186,000	70,000	1,327,000
Total direct operations	551,000	3,325,000	3,671,000	838,000	5,457,000	2,605,000	3,483,000	1,469,000	21,399,000
Appropriation estimate	4,675,000	4,976,000	5,738,000	2,574,000	15,780,000	9,817,000	11,040,000	1,740,000	56,340,000

(P. 979)

Clinical center services to laboratory and patient areas (revised)

	Estimate, 1953		Revised estimate, 1954		Change (+) or (−)	
	Positions	Amount	Positions	Amount	Positions	Amount
Personal services	792	$1,167,842	1,022	$2,444,000	+230	+$1,276,158
Travel		25,500		35,000		+9,500
Transportation of things		4,800		6,800		+2,000
Communication services		41,000		45,000		+4,000
Rents and utility services		1,500		1,500		0
Printing and reproduction		10,000		10,000		0
Other contractual services		10,000		10,000		0
Supplies and materials		259,600		377,200		+117,600
Equipment		19,500		9,500		−10,000
Taxes and assessments		3,100		6,000		+2,900
Deduct quarters and subsistence		−1,642		−60,000		−58,358
Total		1,541,200		2,885,000		+1,343,800
Less reimbursements		−1,541,200		−2,885,000		−1,343,800
Net obligations		0		0		0

(P. 981)

Research services

	Estimate, 1953		Revised estimate, 1954		Change (+) or (−)	
	Positions	Amount	Positions	Amount	Positions	Amount
Personal services	692	$2,021,400	675	$2,329,800	−17	+$308,400
Travel		1,630		1,630		0
Transportation of things		3,000		3,500		+500
Communication services		19,300		19,300		0
Rents and utility services		164,800		257,800		+93,000
Printing and reproduction		19,300		14,300		−5,000
Other contractual services		56,200		41,500		−14,700
Supplies and materials		576,800		675,900		+99,100
Equipment		111,300		46,300		−65,000
Taxes and assessments		7,500		9,200		+1,700
Deduct quarters and subsistence		−1,200		−1,200		0
Total		2,980,000		3,398,000		+418,000
Less reimbursements		−2,980,000		−3,398,000		−418,000
Net obligations		0		0		0

(P. 982)

Administration

	Estimate, 1953		Estimate, 1954		Change (+) or (−)	
	Positions	Amount	Positions	Amount	Positions	Amount
Personal services	149	$629,904	162	$676,904	+13	+$47,000
Travel		8,200		8,200		0
Transportation of things		300		300		0
Communication services		10,500		10,500		0
Rents and utility services		12,000		21,000		+9,000
Printing and reproduction		7,000		7,000		0
Other contractual services		7,200		5,800		−1,400
Supplies and materials		21,000		23,000		+2,000
Equipment		7,500		7,500		0
Taxes and assessments		1,500		1,700		+200
Deduct quarters and subsistence		−4,104		−4,104		0
Total		−701,000		757,800		+56,800
Less reimbursements		701,000		−757,800		−56,800
Net obligations		0		0		0

Estimate of clinical center costs in 1954 based on alternative plans for bed activation

	Starting date for patients	Beds by June 30, 1953	Maximum beds reached in 1954	Date maximum beds reached in 1954	Clinical center services to laboratory and patient areas	Research services	Administration	Clinical investigations	Total
(For comparative purposes)	Apr. 1, 1953	150	300	May	$3,549,500	$1,096,100	$126,700	$1,914,200	$6,686,500
1954 revised budget request	July 1, 1953	0	240	do	2,635,000	946,900	126,700	1,667,100	5,375,700
Alternative plans for 1954:									
1	do	0	250	do	2,900,000	959,000	126,700	1,724,500	5,710,200
2	do	45	300	do	3,320,000	1,096,100	126,700	1,914,200	6,457,000
3	do	0	300	do	3,200,000	1,096,100	126,700	1,914,200	6,337,000

Distribution of costs attributable to clinical center—Revised 1954 budget estimate

	Arthritis		Microbiology		Neurology		Cancer		Mental		Heart		Dental Institute		Total	
	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount	Positions	Amount
FISCAL YEAR 1954																
Research:																
Clinical investigations	48	$282,000	32	$179,100	36	$203,200	57	$326,000	40	$252,800	63	$210,000	18	$135,200	294	$1,588,300
Visiting scientist						10,000		30,000		17,200		6,000		15,600		78,800
Subtotal	48	[1]282,000	32	179,100	36	213,200	57	356,000	40	270,000	63	216,000	18	150,800	294	1,667,100
Clinical center services to laboratory and patient areas		411,000		349,000		302,000		615,000		460,000		481,000		17,000	1,022	2,635,000
Research services		177,400		166,400		32,600		279,800		98,600		159,000		33,100	196	[2]946,900
Subtotal		588,400		515,400		334,600		894,800		558,600		640,000		50,100	1,218	3,581,900
Total research		870,400		694,500		547,800		1,250,800		828,600		856,000		200,900	1,512	5,249,000
Administration		20,600		24,500		3,900		37,200		15,200		20,700		4,700	37	[3]126,700
Total		891,000		719,000		551,600		1,288,000		843,800		876,700		205,600	1,549	5,375,700

[1] Reflects net appropriation request, therefore excludes reimbursements of $250,000 for sale of employee meals.

[2] Indicates share of the $3,398,000 for research services that is attributable to the expanded clinical center operation.

[3] Indicates share of the $757,800 for administration that is due to the expanded clinical center operation.

(P. 988)

Breakdown of the NIH visiting scientist program by research institute—fiscal 1954

Visiting scientist program:	
Arthritis	0
Neurology	$10,000
Cancer	30,000
Mental	17,200
Heart	6,000
Dental	15,600
Total	78,800

GENERAL-PUBLIC HEALTH SERVICE

(P. 1038)

U. S. Public Health Service—Cost of technical assistance to States

Appropriation title	1952 actual		1953 estimate		1954 revised estimate	
	Position	Amount	Position	Amount	Position	Amount
Control of venereal diseases	228	$1,389,897	155	$1,043,000	140	$910,000
Control of tuberculosis	259	1,833,884	232	1,787,480	181	680,000
Assistance to States, general [1]	550	3,156,544	520	3,092,800	559	3,108,000
Control of communicable diseases [2]	1,211	5,616,759	1,118	5,407,750	1,005	4,860,000
Engineering, sanitation, and industrial hygiene [3]	458	2,820,046	438	2,781,000	430	2,773,000
Disease and sanitation investigations and control, Territory of Alaska	16	132,557	18	118,000	14	108,000
Salaries and expenses, hospital construction services [4]	162	1,115,273	162	1,090,440	154	1,021,000
Salaries, expenses, and grants, National Cancer Institute	79	397,074	79	400,000	71	353,000
Mental health activities	66	425,744	59	398,000	54	361,000
Salaries, expenses and grants, National Heart Institute	60	308,416	57	345,000	50	297,000
Dental health activities	119	789,564	119	800,000	103	700,000
Total	3,208	17,985,758	2,957	17,263,470	2,741	15,171,000

[1] Includes vital statistics activity.
[2] Includes general disease-prevention and control activities, specific disease-prevention and contro activities, and general epidemic and disaster aid.
[3] Includes industrial hygiene, water-supply and water-pollution control, and general sanitation activities.
[4] Includes operations and technical services activities.

APPENDIX D

Distribution of General Service Grades, Fiscal Years 1947–52

Department of Health, Education, and Welfare

DEPARTMENTAL SUMMARY

Fiscal year 1947			Fiscal year 1948			Fiscal year 1949			Fiscal year 1950			Fiscal year 1951			Fiscal year 1952		
Grade	Number	Percent of total	Grade	Number	Percent of total	Grade	Number	Percent of total	Grade	Number	Percent of total	Grade	Number	Percent of total	Grade	Number	Percent of total
GS–18			GS–18			GS–18			GS–18			GS–18	2		GS–18	2	
GS–17			GS–17			GS–17			GS–17	2		GS–17	3		GS–17	4	
GS–16	3		GS–16	1		GS–16	2		GS–16	3		GS–16	14		GS–16	14	
GS–15	50	0.2	GS–15	53	0.2	GS–15	80	0.3	GS–15	85	0.3	GS–15	92	0.3	GS–15	89	0.3
GS–14	105	.4	GS–14	137	.5	GS–14	131	.5	GS–14	151	.6	GS–14	204	.7	GS–14	264	.9
GS–13	338	1.3	GS–13	394	1.5	GS–13	487	1.8	GS–13	533	2.0	GS–13	602	2.0	GS–13	610	2.1
GS–12	552	2.1	GS–12	664	2.5	GS–12	720	2.7	GS–12	804	3.0	GS–12	811	2.7	GS–12	789	2.7
GS–11	791	3.0	GS–11	884	3.3	GS–11	944	3.5	GS–11	932	3.5	GS–11	970	3.2	GS–11	952	3.2
GS–10	97	.4	GS–10	142	.5	GS–10	148	.6	GS–10	136	.5	GS–10	148	.5	GS–10	165	.6
GS–9	1,215	4.7	GS–9	1,466	5.6	GS–9	1,589	6.0	GS–9	1,631	6.1	GS–9	1,740	5.8	GS–9	1,739	5.9
GS–8	154	.6	GS–8	196	.7	GS–8	330	1.2	GS–8	379	1.4	GS–8	593	2.0	GS–8	621	2.1
GS–7	1,792	6.9	GS–7	2,116	8.0	GS–7	2,113	7.9	GS–7	2,257	8.4	GS–7	2,403	8.0	GS–7	2,475	8.4
GS–6	680	2.6	GS–6	654	2.5	GS–6	1,787	6.7	GS–6	2,059	7.6	GS–6	1,855	6.2	GS–6	2,384	8.0
GS–5	4,234	16.3	GS–5	3,982	15.1	GS–5	3,408	12.8	GS–5	3,208	11.8	GS–5	4,072	13.6	GS–5	3,623	12.2
GS–4	3,176	12.2	GS–4	3,029	11.5	GS–4	2,628	9.8	GS–4	2,737	10.2	GS–4	3,167	10.6	GS–4	3,047	10.3
GS–3	4,246	16.4	GS–3	4,001	15.2	GS–3	4,445	16.7	GS–3	4,679	17.4	GS–3	5,024	16.9	GS–3	5,950	20.1
GS–2	6,770	26.2	GS–2	6,765	25.7	GS–2	5,755	21.6	GS–2	5,659	21.0	GS–2	6,696	22.5	GS–2	5,806	19.5
GS–1	1,741	6.7	GS–1	1,911	7.2	GS–1	2,120	7.9	GS–1	1,662	6.2	GS–1	1,509	5.0	GS–1	1,087	3.7
Total	25,944	100.0		26,395	100.0		26,687	100.0		26,917	100.0		29,905	100.0		29,621	100.0

GS–18		
GS–17		
GS–16		
GS–15	2	0.2
GS–14	10	.9
GS–13	51	4.6
GS–12	35	3.2
GS–11	100	9.1
GS–10	1	.1
GS–9	213	19.3
GS–8	1	.1
GS–7	251	22.8
GS–6	12	1.1
GS–5	111	10.1
GS–4	96	8.7
GS–3	135	12.3
GS–2	40	3.6
GS–1	43	3.9
Total	1,101	100.0

GS–18		
GS–17		
GS–16		
GS–15	4	0.4
GS–14	17	1.6
GS–13	51	4.8
GS–12	58	5.4
GS–11	118	11.0
GS–10	195	18.2
GS–9	3	.3
GS–8	201	18.7
GS–7	37	3.5
GS–6	144	13.5
GS–5	83	7.8
GS–4	103	9.6
GS–3	30	2.8
GS–2	26	2.4
GS–1		
	1,070	100.0

GS–18		
GS–17		
GS–16		
GS–15	10	0.9
GS–14	13	1.2
GS–13	50	4.7
GS–12	65	6.1
GS–11	127	11.9
GS–10	1	.1
GS–9	188	17.7
GS–8	3	.3
GS–7	191	18.0
GS–6	39	3.7
GS–5	145	13.6
GS–4	86	8.1
GS–3	96	9.0
GS–2	29	2.7
GS–1	21	2.0
	1,064	100.0

GS–18		
GS–17		
GS–16		
GS–15	11	1.1
GS–14	13	1.2
GS–13	53	5.1
GS–12	72	6.9
GS–11	122	11.7
GS–10	1	.1
GS–9	184	17.6
GS–8	3	.3
GS–7	192	18.3
GS–6	46	4.4
GS–5	133	12.7
GS–4	89	8.5
GS–3	91	8.7
GS–2	24	2.3
GS–1	11	1.1
	1,045	100.0

GS–18		
GS–17		
GS–16		
GS–15	1	0.1
GS–14	11	1.0
GS–13	27	2.4
GS–12	43	3.9
GS–11	79	7.1
GS–10	120	10.8
GS–9	2	.2
GS–8	195	17.7
GS–7	2	.2
GS–6	184	16.7
GS–5	50	4.5
GS–4	168	15.2
GS–3	101	9.1
GS–2	91	8.2
GS–1	25	2.3
	7	.6
	1,106	100.0

GS–18		
GS–17		
GS–16	1	0.1
GS–15	11	1.0
GS–14	47	4.3
GS–13	61	5.6
GS–12	57	5.2
GS–11	122	11.2
GS–10	2	.2
GS–9	194	17.8
GS–8	3	.3
GS–7	166	15.2
GS–6	44	4.0
GS–5	167	15.3
GS–4	94	8.6
GS–3	92	8.4
GS–2	22	2.1
GS–1	7	.7
	1,090	100.0

Department of Health, Education, and Welfare—Continued

FREEDMEN'S HOSPITAL

Fiscal year 1947			Fiscal year 1948			Fiscal year 1949			Fiscal year 1950			Fiscal year 1951			Fiscal year 1952		
Grade	Number	Percent of total	Grade	Number	Percent of total	Grade	Number	Percent of total	Grade	Number	Percent of total	Grade	Number	Percent of total	Grade	Number	Percent of total
GS–18			GS–18			GS–18			GS–18			GS–18			GS–18		
GS–17			GS–17			GS–17			GS–17			GS–17			GS–17		
GS–16			GS–16			GS–16			GS–16			GS–16			GS–16		
GS–15			GS–15			GS–15			GS–15			GS–15			GS–15		
GS–14	1	0.3	GS–14	1	0.2	GS–14	1	0.2	GS–14	1	0.2	GS–14	1	0.2	GS–14	1	0.2
GS–13			GS–13			GS–13			GS–13			GS–13	1	.2	GS–13	2	.4
GS–12			GS–12	4	.7	GS–12	4	.7	GS–12	4	.7	GS–12	2	.4	GS–12	1	.2
GS–11	2	.7	GS–11	4	.7	GS–11	4	.7	GS–11	4	.7	GS–11	5	.9	GS–11	6	1.1
GS–10			GS–10			GS–10			GS–10			GS–10			GS–10		
GS–9	8	2.7	GS–9	28	5.2	GS–9	26	4.8	GS–9	23	4.1	GS–9	27	5.1	GS–9	26	4.9
GS–8	1	.3	GS–8			GS–8			GS–8			GS–8			GS–8	1	.2
GS–7	35	11.9	GS–7	53	9.8	GS–7	59	10.8	GS–7	56	10.1	GS–7	51	9.7	GS–7	50	9.5
GS–6	1	.3	GS–6	3	.6	GS–6	4	.7	GS–6	4	.7	GS–6	4	.8	GS–6	4	.8
GS–5	139	47.4	GS–5	222	41.1	GS–5	217	39.8	GS–5	240	43.3	GS–5	212	40.1	GS–5	213	40.3
GS–4	21	7.1	GS–4	18	3.3	GS–4	20	3.7	GS–4	20	3.6	GS–4	20	3.8	GS–4	26	4.9
GS–3	25	8.5	GS–3	96	17.7	GS–3	99	18.2	GS–3	93	16.8	GS–3	95	18.0	GS–3	90	17.0
GS–2	40	13.7	GS–2	33	6.1	GS–2	33	6.1	GS–2	29	5.2	GS–2	29	5.5	GS–2	86	16.3
GS–1	21	7.1	GS–1	79	14.6	GS–1	78	14.3	GS–1	81	14.6	GS–1	81	15.3	GS–1	22	4.2
Total	294	100.0		541	100.0		545	100.0		555	100.0		528	100.0		528	100.0

OFFICE OF EDUCATION

GS–18			GS–18			GS–18			GS–18			GS–18	1	0.3	GS–18	1	0.2
GS–17			GS–17			GS–17			GS–17			GS–17			GS–17		
GS–16			GS–16			GS–16			GS–16			GS–16	1	.3	GS–16	1	.2
GS–15	10	3.6	GS–15	11	3.6	GS–15	11	3.6	GS–15	10	3.2	GS–15	9	2.3	GS–15	9	2.1
GS–14	20	7.3	GS–14	28	9.2	GS–14	28	9.2	GS–14	28	9.1	GS–14	33	8.5	GS–14	47	10.9
GS–13	49	17.9	GS–13	53	17.4	GS–13	52	17.0	GS–13	53	17.1	GS–13	86	22.1	GS–13	90	20.9
GS–12	30	11.0	GS–12	46	15.1	GS–12	42	13.7	GS–12	41	13.3	GS–12	36	9.2	GS–12	28	6.5
GS–11	9	3.3	GS–11	5	1.7	GS–11	3	1.0	GS–11	7	2.3	GS–11	13	3.3	GS–11	16	3.7
GS–10			GS–10			GS–10			GS–10			GS–10			GS–10		
GS–9	17	6.2	GS–9	12	4.0	GS–9	14	4.6	GS–9	11	3.6	GS–9	18	4.6	GS–9	32	7.4
GS–8			GS–8			GS–8			GS–8			GS–8			GS–8		
GS–7	11	4.0	GS–7	10	3.3	GS–7	14	4.6	GS–7	13	4.2	GS–7	15	3.9	GS–7	17	3.9
GS–6	16	5.8	GS–6	14	4.6	GS–6	15	4.9	GS–6	15	4.8	GS–6	15	3.9	GS–6	14	3.3
GS–5	26	9.5	GS–5	30	9.9	GS–5	38	12.4	GS–5	38	12.3	GS–5	44	11.3	GS–5	52	12.0
GS–4	51	18.6	GS–4	59	19.4	GS–4	57	18.6	GS–4	58	18.8	GS–4	77	19.8	GS–4	104	24.1
GS–3	30	10.9	GS–3	31	10.2	GS–3	28	9.1	GS–3	30	9.7	GS–3	35	9.0	GS–3	16	3.7
GS–2	4	1.5	GS–2	4	1.3	GS–2	3	1.0	GS–2	4	1.3	GS–2	5	1.3	GS–2	4	.9
GS–1	1	.4	GS–1	1	.3	GS–1	1	.3	GS–1	1	.3	GS–1	1	.2	GS–1	1	.2
Total	274	100.0		304	100.0		306	100.0		309	100.0		389	100.0		432	100.0

Total	274	100.0		304	100.0		306	100.0		309	100.0		389	100.0		432	100.0	

OFFICE OF VOCATIONAL REHABILITATION

GS-18			GS-18			GS-18			GS-18			GS-18			GS-18			
GS-17			GS-17			GS-17			GS-17			GS-17			GS-17			
GS-16			GS-16			GS-16			GS-16			GS-16			GS-16	1	0.8	
GS-15	1	0.6	GS-15	1	0.8	GS-15	1	0.7	GS-15	1	0.7	GS-15	1	0.7	GS-15			
GS-14	4	2.3	GS-14	4	3.0	GS-14	4	3.0	GS-14	4	2.9	GS-14	4	2.9	GS-14	6	4.8	
GS-13	14	8.1	GS-13	11	8.3	GS-13	15	11.1	GS-13	15	10.9	GS-13	16	11.5	GS-13	17	13.7	
GS-12	21	12.2	GS-12	14	10.5	GS-12	11	8.1	GS-12	14	10.2	GS-12	15	10.8	GS-12	12	9.7	
GS-11	22	12.8	GS-11	18	13.5	GS-11	17	12.6	GS-11	15	10.9	GS-11	18	12.9	GS-11	14	11.3	
GS-10			GS-10			GS-10			GS-10			GS-10			GS-10			
GS-9	15	8.7	GS-9	14	10.5	GS-9	14	10.4	GS-9	14	10.2	GS-9	12	8.6	GS-9	11	8.9	
GS-8	1	.6	GS-8	1	.8	GS-8	1	.7	GS-8	1	.7	GS-8	1	.7	GS-8	1	.8	
GS-7	16	9.3	GS-7	9	6.8	GS-7	8	5.9	GS-7	9	6.7	GS-7	10	7.2	GS-7	7	5.6	
GS-6	1	.6	GS-6			GS-6			GS-6			GS-6	2	1.4	GS-6	1	.8	
GS-5	14	8.1	GS-5	16	12.0	GS-5	19	14.1	GS-5	19	13.9	GS-5	14	10.1	GS-5	16	12.9	
GS-4	26	15.2	GS-4	22	16.5	GS-4	22	16.3	GS-4	20	14.6	GS-4	21	15.2	GS-4	19	15.4	
GS-3	31	18.0	GS-3	20	15.0	GS-3	20	14.9	GS-3	22	16.1	GS-3	23	16.6	GS-3	18	14.5	
GS-2	6	3.5	GS-2	3	2.3	GS-2	3	2.2	GS-2	3	2.2	GS-2	2	1.4	GS-2	1	.8	
GS-1			GS-1			GS-1			GS-1			GS-1			GS-1			
Total	172	100.0		133	100.0		135	100.0		137	100.0		139	100.0		124	100.0	

PUBLIC HEALTH SERVICE

GS-18			GS-18			GS-18			GS-18			GS-18			GS-18			
GS-17			GS-17			GS-17			GS-17			GS-17			GS-17			
GS-16			GS-16			GS-16			GS-16	1		GS-16	6	0.1	GS-16	5		
GS-15	12	0.1	GS-15	12	0.1	GS-15	17	0.2	GS-15	23	0.2	GS-15	29	.3	GS-15	24	0.2	
GS-14	19	.2	GS-14	33	.4	GS-14	40	.4	GS-14	59	.6	GS-14	67	.6	GS-14	82	.8	
GS-13	64	.7	GS-13	115	1.2	GS-13	154	1.6	GS-13	203	1.9	GS-13	247	2.4	GS-13	234	2.3	
GS-12	174	1.9	GS-12	227	2.5	GS-12	288	2.9	GS-12	352	3.3	GS-12	345	3.3	GS-12	353	3.5	
GS-11	306	3.3	GS-11	366	4.0	GS-11	416	4.2	GS-11	421	4.0	GS-11	415	4.0	GS-11	407	4.0	
GS-10	20	.2	GS-10	29	.3	GS-10	28	.3	GS-10	28	.3	GS-10	22	.2	GS-10	25	.2	
GS-9	431	4.7	GS-9	527	5.7	GS-9	614	6.2	GS-9	645	6.1	GS-9	688	6.6	GS-9	688	6.8	
GS-8	32	.3	GS-8	38	.4	GS-8	36	.4	GS-8	24	.2	GS-8	30	.3	GS-8	31	.3	
GS-7	628	6.8	GS-7	682	7.4	GS-7	812	8.2	GS-7	859	8.2	GS-7	987	9.5	GS-7	916	9.1	
GS-6	257	2.8	GS-6	321	3.5	GS-6	294	3.0	GS-6	280	2.7	GS-6	254	2.4	GS-6	267	2.7	
GS-5	2,041	22.0	GS-5	1,848	19.9	GS-5	2,008	20.1	GS-5	2,177	20.6	GS-5	2,153	20.8	GS-5	2,166	21.6	
GS-4	1,403	15.2	GS-4	1,312	14.2	GS-4	1,419	14.3	GS-4	1,559	14.8	GS-4	1,794	17.2	GS-4	1,731	17.3	
GS-3	2,157	23.3	GS-3	1,761	19.1	GS-3	1,848	18.5	GS-3	2,117	20.1	GS-3	1,864	17.9	GS-3	1,723	17.2	
GS-2	1,472	15.9	GS-2	1,174	12.7	GS-2	1,052	10.6	GS-2	964	9.2	GS-2	806	7.7	GS-2	917	9.1	
GS-1	244	2.6	GS-1	796	8.6	GS-1	906	9.1	GS-1	819	7.8	GS-1	694	6.7	GS-1	494	4.9	
Total	9,260	100.0		9,241	100.0		9,932	100.0		10,531	100.0		10,401	100.0		10,063	100.0	

Department of Health, Education, and Welfare—Continued

ST. ELIZABETHS HOSPITAL

Fiscal year 1947			Fiscal year 1948			Fiscal year 1949			Fiscal year 1950			Fiscal year 1951			Fiscal year 1952		
Grade	Number	Percent of total	Grade	Number	Percent of total	Grade	Number	Percent of total	Grade	Number	Percent of total	Grade	Number	Percent of total	Grade	Number	Percent of total
GS–18			GS–18			GS–18			GS–18			GS–18			GS–18		
GS–17			GS–17			GS–17			GS–17	1	0.1	GS–17	1	0.1	GS–17	1	0.1
GS–16			GS–16			GS–16			GS–16			GS–16			GS–16		
GS–15	3	0.2	GS–15	3	0.2	GS–15	3	0.2	GS–15	3	.2	GS–15	3	.2	GS–15	6	.3
GS–14	4	.2	GS–14	5	.3	GS–14	5	.3	GS–14	5	.3	GS–14	5	.3	GS–14	13	.7
GS–13	13	.7	GS–13	16	.9	GS–13	20	1.2	GS–13	19	1.1	GS–13	21	1.2	GS–13	11	.6
GS–12	10	.6	GS–12	10	.6	GS–12	20	1.2	GS–12	18	1.1	GS–12	24	1.4	GS–12	33	1.9
GS–11	21	1.2	GS–11	22	1.3	GS–11	25	1.5	GS–11	26	1.5	GS–11	21	1.2	GS–11	18	1.0
GS–10	2	.1	GS–10	3	.2	GS–10	3	.2	GS–10	2	.1	GS–10	2	.1	GS–10	1	.1
GS–9	76	4.5	GS–9	83	4.9	GS–9	74	4.4	GS–9	82	4.8	GS–9	82	4.8	GS–9	87	4.9
GS–8	1	.1	GS–8	2	.1	GS–8	1	.1	GS–8	2	.1	GS–8	2	.1	GS–8	2	.1
GS–7	167	9.8	GS–7	180	10.6	GS–7	172	10.2	GS–7	204	12.0	GS–7	199	11.7	GS–7	203	11.5
GS–6	10	.6	GS–6	8	.5	GS–6	8	.5	GS–6	9	.5	GS–6	9	.5	GS–6	10	.6
GS–5	70	4.1	GS–5	85	5.0	GS–5	101	6.0	GS–5	71	4.2	GS–5	85	5.0	GS–5	117	6.6
GS–4	58	3.4	GS–4	54	3.1	GS–4	63	3.7	GS–4	64	3.8	GS–4	58	3.4	GS–4	77	4.4
GS–3	301	17.7	GS–3	326	19.3	GS–3	317	18.7	GS–3	309	18.2	GS–2	300	17.7	GS–3	290	16.4
GS–2	699	41.1	GS–2	765	45.3	GS–2	705	41.7	GS–2	768	45.4	GS–2	710	41.9	GS–2	783	44.2
GS–1	267	15.7	GS–1	131	7.7	GS–1	171	10.1	GS–1	112	6.6	GS–1	176	10.4	GS–1	116	6.6
Total	1,702	100.0		1,693	100.0		1,688	100.0		1,695	100.0		1,698	100.0		1,768	100.0

SOCIAL SECURITY ADMINISTRATION

GS–18			GS–18			GS–18			GS–18			GS–18			GS–18		
GS–17			GS–17			GS–17			GS–17	1		GS–17	1		GS–17	1	
GS–16	3		GS–16			GS–16			GS–16	1		GS–16	3		GS–16	3	
GS–15	12	0.1	GS–15	12	0.1	GS–15	14	0.1	GS–15	12	0.1	GS–15	13	0.1	GS–15	13	0.1
GS–14	31	.2	GS–14	19	.2	GS–14	20	.2	GS–14	23	.2	GS–14	44	.3	GS–14	44	.3
GS–13	113	.9	GS–13	95	.8	GS–13	103	.9	GS–13	101	.9	GS–13	104	.7	GS–13	111	.8
GS–12	242	1.9	GS–12	215	1.7	GS–12	221	1.8	GS–12	236	2.0	GS–12	252	1.7	GS–12	265	1.8
GS–11	295	2.3	GS–11	288	2.3	GS–11	294	2.5	GS–11	287	2.5	GS–11	311	2.1	GS–11	322	2.2
GS–10	74	.6	GS–10	90	.7	GS–10	100	.8	GS–10	95	.8	GS–10	110	.7	GS–10	121	.8
GS–9	428	3.4	GS–9	521	4.2	GS–9	578	4.8	GS–9	601	5.1	GS–9	649	4.4	GS–9	643	4.4
GS–8	113	.9	GS–8	126	1.0	GS–8	265	2.2	GS–8	328	2.8	GS–8	539	3.7	GS–8	567	3.9
GS–7	665	5.2	GS–7	907	7.3	GS–7	793	6.6	GS–7	863	7.4	GS–7	898	6.1	GS–7	1,056	7.2
GS–6	376	2.9	GS–6	249	2.0	GS–6	1,401	11.7	GS–6	1,678	14.4	GS–6	1,490	10.2	GS–6	2,005	13.6
GS–5	1,794	14.1	GS–5	1,533	12.3	GS–5	778	6.5	GS–5	432	3.7	GS–5	1,297	8.8	GS–5	803	5.5
GS–4	1,478	11.6	GS–4	1,351	10.9	GS–4	787	6.6	GS–4	758	6.5	GS–4	898	6.1	GS–4	809	5.5
GS–3	1,491	11.7	GS–3	1,483	12.0	GS–3	1,855	15.5	GS–3	1,836	15.7	GS–3	2,459	16.8	GS–3	3,576	24.3
GS–2	4,472	35.1	GS–2	4,652	37.5	GS–2	3,847	32.0	GS–2	3,800	32.5	GS–2	5,057	34.5	GS–2	3,927	26.6
GS–1	1,161	9.1	GS–1	872	7.0	GS–1	939	7.8	GS–1	637	5.4	GS–1	549	3.8	GS–1	444	3.0
Total	12,748	100.0		12,413	100.0		11,995	100.0		11,689	100.0		14,674	100.0		14,710	100.0

Total	12,748	100.0		12,413	100.0		11,995	100.0		11,689	100.0		14,674	100.0		14,710	100.0	

OFFICE OF SECRETARY

GS–18			GS–18			GS–18			GS–18			GS–18	1	0.1	GS–18	1	0.1	
GS–17			GS–17			GS–17			GS–17			GS–17	1	.1	GS–17	2	.2	
GS–16			GS–16	1	0.1	GS–16	2	0.2	GS–16	1	0.1	GS–16	3	.3	GS–16	3	.3	
GS–15	10	2.5	GS–15	10	1.0	GS–15	24	2.3	GS–15	25	2.6	GS–15	26	2.7	GS–15	26	2.9	
GS–14	16	4.1	GS–14	30	3.0	GS–14	20	2.0	GS–14	18	1.9	GS–14	23	2.4	GS–14	24	2.6	
GS–13	34	8.7	GS–13	53	5.3	GS–13	93	9.1	GS–13	89	9.3	GS–13	84	8.7	GS–13	84	9.3	
GS–12	40	10.2	GS–12	90	9.0	GS–12	69	6.8	GS–12	67	7.0	GS–12	58	6.0	GS–12	40	4.4	
GS–11	36	9.2	GS–11	63	6.3	GS–11	58	5.7	GS–11	50	5.2	GS–11	67	6.9	GS–11	47	5.2	
GS–10			GS–10	20	2.0	GS–10	16	1.6	GS–10	10	1.0	GS–10	12	1.2	GS–10	16	1.8	
GS–9	27	6.9	GS–9	86	8.6	GS–9	81	7.9	GS–9	71	7.4	GS–9	69	7.1	GS–9	58	6.4	
GS–8	5	1.3	GS–8	26	2.6	GS–8	24	2.3	GS–8	21	2.2	GS–8	19	2.0	GS–8	16	1.8	
GS–7	19	4.8	GS–7	74	7.4	GS–7	64	6.3	GS–7	61	6.4	GS–7	59	6.1	GS–7	60	6.6	
GS–6	7	1.8	GS–6	22	2.2	GS–6	26	2.5	GS–6	27	2.8	GS–6	31	3.2	GS–6	39	4.3	
GS–5	39	9.9	GS–5	104	10.4	GS–5	102	10.0	GS–5	98	10.3	GS–5	99	10.2	GS–5	89	9.8	
GS–4	43	10.9	GS–4	130	13.0	GS–4	174	17.0	GS–4	169	17.8	GS–4	198	20.3	GS–4	187	20.7	
GS–3	76	19.2	GS–3	181	18.1	GS–3	182	17.8	GS–3	181	18.9	GS–3	157	16.2	GS–3	145	16.0	
GS–2	37	9.4	GS–2	104	10.4	GS–2	83	8.1	GS–2	67	7.0	GS–2	62	6.4	GS–2	66	7.3	
GS–1	4	1.0	GS–1	6	.6	GS–1	4	.4	GS–1	1	.1	GS–1	1	.1	GS–1	3	.3	
Total	393	100.0		1,000	100.0		1,022	100.0		956	100.0		970	100.0		906	100.0	

LIST OF WITNESSES

	Page
Abbey, L. B.	678
Anderson, Dr. O. L.	555, 594, 611, 632, 678, 697, 742
Anderson, Dr. R. J.	611
Andrews, Dr. J. M.	678
Arnold, Dr. F. A., Jr.	1065
Bailey, Dr. Pearce	1116
Banta, P. M.	1176, 1259, 1278
Beardwood, J. B.	1278
Cronin, Dr. J. W.	751, 872
Dearing, Dr. W. P.	555
Drescher, Dr. E. C.	1159
Feist, Elsie	930
Felix, Dr. R. H.	1024
Gregg, Dr. Ralph	930
Haas, Dr. Victor	1097
Haldemann, Dr. J. C.	632, 742
Hambleton, Walter	1210
Harlow, R. L.	555, 1145, 1159, 1162, 1288
Heller, Dr. J. R.	1000
Hilsenroth, Charles	751
Hobby, Hon. O. C.	1176, 1278
Hoff, Miss Hannah	594, 611
Hoge, Dr. V. M.	751, 890
Hollis, M. D.	697, 729
Hunt, Dr. G. H.	890, 930
Hunt, Dr. Halsey	555
Hyde, Dr. H. V. Z.	1139, 1162
Knutson, Dr. J. W.	1065
Learmouth, R. E.	940
Lund, C. B.	1236, 1248
MacKenzie, V. G.	697
Masur, Dr. Jack	930
McGibony, Dr. John	751, 872
Miles, R. E., Jr.	1176, 1210, 1236, 1278
Miller, L. L.	1210
Perrott, George	1139, 1162
Ranney, R. R.	890
Scheele, Dr. L. A.	555, 1288
Schwob, Carl	697, 729
Sebrell, Dr. W. H.	555, 940, 1139, 1288
Seggel, Richard	632, 697
Shafer, Dr. J. K.	594
Shannon, Dr. J. A.	940
Shaw, Dr. J. R.	890
Siepert, A. F.	940, 1139
Spencer, Dr. C. B.	930
Stephens, M. A.	555, 1176, 1210, 1236, 1248, 1259, 1278, 1288
Tibbetts, Clark	1210
Van Slyke, Dr. C. J.	940, 1046
Wilder, Dr. R. M.	1081
Willcox, A. W.	1259
Wilson, George	751
Woodward, Mrs. E. S.	1210

INDEX

A

Page

Administrative expenses, 1953, statement of 1267

C

Columbia Institution for the Deaf, revision of budget estimates 1316

E

Education, Office of, revision of budget estimates 1178, 1182
  Further endowment of colleges and the mechanic arts 1178
  Salaries and expenses 1178, 1190, 1327
  School construction 1329
    School districts, payments to 1178, 1184, 1194, 1198, 1328
  Veterans' Educational Program, Salaries and expenses 1183, 1190
  Vocational education, promotion and further development of 1182, 1326
Estimates, 1954, distribution of 1375

F

Field Offices, Office of 1236
Food and Drug Administration, revision of budget estimates 1319
Freedmen's Hospital, revision of budget estimates 1320

G

General Counsel, Office of 1259
General Service grades, distribution of 1388
Howard University:
  Revision of budget estimates:
    Construction 1177, 1324
    Plans and specifications 1323
    Salaries and expenses 1177, 1322
  Unexpended balances for construction at 1276

P

Public Health Service 555
  Administrative costs, 1952–54 1173
  Alaska, disease and sanitation investigations and control 742
    Revised budget estimates 1297, 1338
  Appropriations and estimates, 1945–54 ..... 588, 1380
  Arthritis and metabolic disease activities 1081
    Revised budget estimates 1357
  Assistance to States, general 632
    Distribution of Federal health funds 642
    Field staff, technical assistance activities of 646
    Grant appropriations and expenditures 1947–54 641
    Medical rehabilitation, relation to vocational rehabilitation program 644
    Revised budget estimates 1297, 1334
    State personnel supported by Federal funds 1298
    Total health expendtures, relation of Federal grants to 637
    Vital statistics, National Office of 636, 642, 675

Public Health Service—Continued — Page

- Communicable diseases, control of — 678
  - Budget revision — 1297, 1335
  - Epidemics:
    - Outbreaks, 1952 — 695
    - Problem of — 562, 681
    - Special fund for — 688
  - Insect and rodent control, relation to work of other agencies — 683, 693
  - Laboratory diagnosis performed for State and local agencies — 690
  - Malaria, incidence of — 688
  - Reimbursements — 689
  - Water resources projects, work in connection with federally sponsored — 691
- Dental health activities — 1065
  - Clinical center, activities at — 1075
  - New treatments, acceptance of — 1071
  - Revised budget estimates — 1355
  - Technical assistance to States — 1074, 1079
  - Water fluoridation — 1073
- Engineering, sanitation, and industrial hygiene — 697
  - Environmental Health Center:
    - Building cost — 720
    - Delay in occupancy of — 712
    - Personnel for — 708
    - Scientific equipment — 722
  - Flood Control Act, 1950, activities under — 710
  - Industrial health center — 719
  - Revision of budget estimates — 1297, 1336
  - Vesicular exanthema, cooperation with Agriculture Department in control of — 705
- Expenditures and additions to functions 1945–54 — 587, 1380
- Fellowship award program — 590, 965
- Foreign quarantine service — 930
  - Revised budget estimate — 1298, 1345
- Health programs, responsibility for — 625
- Hospitals and medical care — 890
  - Carville Hospital:
    - Patients, responsibility of families for — 901
    - Per diem rate at — 927
  - Cost of food — 913, 1381
  - Farm operations at hospitals — 918, 927
  - Medical and vocational rehabilitation — 905, 914
  - Nonreimbursable and reimbursable patient load — 907, 1380
  - Outpatient clinics and offices, need for — 917
  - Patient load and outpatient visits, average daily — 906
    - Neuropsychiatric hospitals, status of patients at — 902, 921
  - Revised budget estimates — 1204, 1298, 1309, 1343
  - Salaries and expenses — 890
  - Seamen's medical care — 897
  - Surplus hospitals, etc., disposition of — 925
- Hospital construction, grants for — 751
  - Allotment formula — 758
  - Allotments, 1948–53 — 764
  - Appropriations, carryover of — 792
  - Auditing of completed projects — 870, 1244
  - Authorizations and appropriations, status of — 793, 854
  - Bed deficiency, cost of overcoming — 851
  - Butler County Memorial Hospital, remodeling of — 864
  - Costs per bed, variations in — 861
  - Doctors in nonurban areas — 771, 857
  - Federal and State obligations and expenditures, 1948–53 — 845
  - Federal funds, distribution of — 796
  - Hill-Burton hospitals:
    - Closed hospitals — 787
    - Occupancy, percentage of — 771, 853
    - Selected States, data on projects in — 775
  - Hospital facilities survey, unexpended balances for — 1276

Public Health Service—Continued
Hospital construction, grants for—Continued — Page
Indianapolis, food service center at — 789
Nursing staffs — 770, 773
RFC loans — 756
Revised budget estimates — 1179, 1202, 1298, 1307, 1339
Southern health centers, approval of — 769
Split technique of financing projects — 855, 858
Standards, determination of — 757
Survey and planning — 755, 850
Teaching facilities — 757
Hospital construction services, salaries and expenses — 872
Administrative services — 882
Federal responsibility for — 887
Grant appropriation, relation to — 882
Headquarters and field organizational units — 875
Hospital and Medical Resources, Division of — 879
Revised budget estimates — 1298, 1341
Technical Services Branch, Division of Hospital Facilities — 874, 879
Medical research — 558, 563, 593
Expenditures for — 593
Grants, procedure for approving — 564
Mental health activities — 1024
Clinical center, funds for — 1035
Cost of mental illness — 1042
Drug addiction problem, work on — 1035
Fellows and trainees who later enter private practice — 1043
Patient load, increase in — 1039
Revised budget estimates — 1351
Schizophrenia — 1040
Technical assistance to States — 1036
Training grants — 1033
Microbiology activities — 1097
Control of communicable diseases, relation to — 1106, 1112
Foreign tropical diseases — 1108
Greece, assistance to — 1115
Revised budget estimates — 1359
Schistosomiasis work in Egypt and elsewhere — 1107
Sectional research program — 1111
Virus diseases — 1105
Motor vehicles — 648
National advisory councils and study sections — 565
National Cancer Institute — 1000
American Cancer Society, cooperation with — 1007, 1023
Atomic Energy Commission, research by — 1010
Clinical center, increase for — 1009, 1023
Comparative transfers — 1008
Lung cancer, incidence of — 1018
Recent accomplishments — 1015
Research fellowship program — 1019
Revised budget estimates — 1349
Specialized training program — 1020
Teaching grant program — 1021
National Heart Institute — 1046
Aging, cooperative research on problem of — 1057, 1059, 1064
American Heart Association, research by — 1055
Comparative transfers — 1057
Need for program — 1063
Recent developments — 1060
Rehabilitation program, relation to other agencies — 1058
Revised budget estimates — 1353
National Institutes of Health — 940
Administration — 986
Budget, 1954, breakdown by functional category — 975, 1383
Clinical center:
Costs, distribution of — 977, 985, 1386
Opening of — 584, 948, 995, 1195

Public Health Service—Continued
National Institutes of Health—Continued
Clinical center—Continued
Page
Operation, cost of 979, 1384
Program, 1954, for operation of 956
Projects, relocation of 986, 988
Rate of bed activation, possibility of lowering 1295, 1305, 1313
Reimbursement from patients 990
Staffing of 584, 594
Common cold, Research on 961
Direct operations, review and approval of grants 962, 987
Fellowship program 590, 965, 991
Field staff 986
Operating expenses 940
Projects, location of 986, 988
Research facilities, grants for construction of 974
Research grants 953, 958
Detection, diagnosis, and other control services, grants for 970
Review and approach of grants, man-years and cost involved in 963, 1382
Revised budget estimates 1179, 1196, 1202, 1288, 1347
Grants 1292
Laboratory and clinical research 1294, 1296
Study sections and advisory groups, payment of 964
Training grants and training stipends 969
Fellows and clinical trainees who subsequently enter private practice 991
Visiting scientists, entertainment of 987
National Science Foundation 1136
Neurology and blindness activities 1116
Brain tumors 1131
Cerebal palsy 1128
Clinical center activities, funds for 1124
Epilepsy 1129
Grants program, basis for estimate for 1123
Herpes zoster 1125
Medical research, importance of 1133
Multiple schlerosis 1127
Muscular distrophy 1128
Revised budget estimates 1361
Voluntary agencies, work of 1125
Private contributions to health activities 590
Program reductions, basis and effect of 1196, 1205, 1208, 1285, 1301
Radiological work 1011
Research facilities, construction of 1139
Revised budget estimates 1363
Retired pay of commissioned officers 1159
Revised budget estimates 1298, 1364
Revision of budget estimates 1178, 1196, 1198, 1204, 1205, 1208, 1288, 1335
Salaries and expenses 1162
Administrative costs, 1952–54 1173
Average grades 1174
International health activities 1170
Public health methods and reports 1165
Revised budget estimates 1365
Travel 1174
Service and supply fund 1145
State health agency funds, 1943–52 588
Statement of the 555
Surgeon General, Office of: Revised Budget estimates 1298
Technical assistance to States, 1952–54 1038, 1387
Tuberculosis, control of 611
Administrative services, Staff for 625
Grant funds, distribution of 616
Mass chest X-ray program 618, 627, 1306
New drugs 591, 593, 623, 625

Public Health Service—Continued
Tuberculosis, control of—Continued — Page
Radiological health services — 623
Revised Budget estimates — 1179, 1297, 1300, 1331
State and local expenditures, comparison of Federal grants to — 616
State programs — 629
Veneral diseases, control of — 594
Deaths from syphilis — 606
Grants, distribution by States — 605
Revised Budget estimates — 1179, 1296, 1297, 1331
State support of program — 598
Transfers to other appropriations — 603
Water pollution control, grants — 729
New Mexico, use of funds in — 738
Other Federal agencies and States, relationship to — 737
Potomac River commission — 739
Projects and States to receive 1954 funds — 733
Revised budget estimates — 1179, 1297, 1337
State reporting, requirements for — 740
Unexpended balances — 1269

R

Revisions of budget estimates — 1176, 1281, 1316
Construction projects, freeze on — 1207
Education, Office of:
Further endowment of colleges and the mechanic arts — 1178
Salaries and expenses — 1178, 1199, 1327
School construction — 1329
School districts, payments to — 1178, 1184, 1194, 1198, 1328
Veterans' educational program, salaries and expenses — 1183, 1199
Vocational education, promotion and further development of — 1182, 1326
Howard University — 1177
Construction — 1177, 1324
Plans and specifications — 1323
Salaries and expenses — 1177, 1322
Public Health Service:
Alaska, Territory of, disease and sanitation investigations and control — 1297, 1338
Arthritis and metabolic disease activities — 1357
Assistance to States, general — 1297, 1334
Communicable diseases, control of — 1297, 1335
Dental health activities — 1355
Engineering, Sanitation, and Industrial Hygiene — 1297, 1336
Foreign quarantine service — 1298, 1345
Hospital and medical care — 1179, 1204, 1298, 1309, 1343
Hospital construction — 1179, 1202, 1298, 1307, 1339
Hospital construction services, salaries and expenses — 1298, 1341
Mental health activities — 1351
Microbiology activities — 1359
National Cancer Institute — 1349
National Heart Institute — 1353
National Institutes of Health — 1179, 1196, 1202, 1288, 1347
Grants — 1292
Laboratory and clinical research — 1294, 1296
Neurology and blindness activities — 1361
Program reductions, basis and effect of — 1196, 1205, 1208, 1285
Research facilities, construction of — 1363
Retired pay, commissioned officers — 1298, 1364
Salaries and expenses — 1365
Surgeon General, office of — 1298
Tuberculosis, control of — 1179, 1297, 1300, 1331
Venereal diseases, control of — 1179, 1296, 1297, 1331
Water pollution control, grants — 1179, 1297, 1337

Revisions of budget estimates—Continued
St. Elizabeths Hospital: Page
Major repairs and preservation of buildings and grounds 1368
Salaries and expenses 1366
Secretary, Office of the 1372
Social Security Administration 1179, 1282, 1369
Children's Bureau:
Grants 1179, 1187, 1370
Salaries and expenses 1369
Old Age and Survivors Insurance, Bureau of 1179
Public Assistance, Bureau of:
Grants, possibility of reducing 1282
Salaries and expenses 1179, 1187
Vocational rehabilitation 1178, 1330

S

St. Elizabeths Hospital, revision of budget estimates:
Major repairs and preservation of buildings and grounds 1368
Salaries and expenses 1366
School facilities survey, unexpended balances for 1273
Secretary:
Office of 1210
Aging and geriatrics, Division of 1232
Budget request, breakdown of 1221
Defense community facilities and services, unexpended balances for 1270
Defense planning officer 1214, 1216
Personnel increases 1213, 1228, 1278
Reorganization plan, effect of 1180, 1278
Revision of budget estimates 1372
Salaries and expenses 1210
Special Assistant to the Secretary 1213, 1231
Transfer authority (*see also* "Statement of the Secretary," this index) 1215
Statement of 1176, 1278
Clinical health center, delay in opening of 1195
Departmental policy development and planning 1180
Federal grant-in-aid programs, review of 1191
International activities, sources of funds for 1187
Revisions of budget estimates (*see also* this title, this index) 1176, 1281
Transfer of appropriations, general authority for 1182, 1189, 1192
Social Security Administration, revision of budget estimates:
Children's Bureau:
Grants 1179, 1187, 1370
Salaries and expenses 1369
Old Age and Survivors Insurance, Bureau of 1179
Public Assistance, Bureau of:
Grants, possibility of reducing 1282
Salaries and expenses 1179, 1187
Surplus property disposal 1248

U

Unexpended balances 1269

V

Vocational Rehabilitation, revision of budget estimates 1178, 1330

W

Working capital fund 1265

○